# Community Health Education in Developing Countries

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## PREFACE

This small book arose out of a study commissioned by the Commonwealth Secretariat in London, to collect information about community health education in Commonwealth countries, looking at activities and programmes relating to primary health care (Community Health Education in Commonwealth Countries 1983). In the course of collecting data it became clear that while there was a mass of information about the industrialized world, this was not true of the third world, and what existed was scattered. It was also clear that many of the problems faced by health educators in different countries were similar, and that an exchange of information about programmes and projects as well as more abstract concepts could be useful. In doing a literature search we came across interesting material from countries outside the Commonwealth and although some of this material is mentioned in our original report, much had to be set aside. Given the great interest in health education and the paucity of information sources, it seemed to us wrong to waste such a valuable store of literature.

This book thus contains a selection of annotated references about community health education in the less developed countries of the world. Examples from the industrialized world have not been included, although there may be a few references to specific projects. The introductory essay puts health education into a historical context, tracing the change in emphasis that has occurred from information to education to promotion; it gives a brief overview of approaches used in community health education and ends with some of the policy implications for health education. The annotated references that follow are divided into five sections: the first covers some of the theoretical concepts,

the debate about mass media approaches and the change in official thinking. The second explores community resources in health education: how communities are and can be involved. The third section looks at selected specific community health education programmes. There are two final sections which include materials and resource centres which should be of particular interest to health educators.

There are many caveats to be borne in mind. We have gleaned information from published sources: many excellent projects remain hidden, unpublicised. We have used English language sources: there are undoubtedly many we have missed in other languages. Nevertheless we believe that what is covered in this book is a reflection of what is happening around the world, and that it is useful as an overview of issues, and as a pointer to other sources of information and resources. Thus it should be of use to health educators, policy-makers and planners in health, teachers and trainers, and students of health education.

# COMMUNITY HEALTH EDUCATION IN DEVELOPING COUNTRIES

## Changing concepts

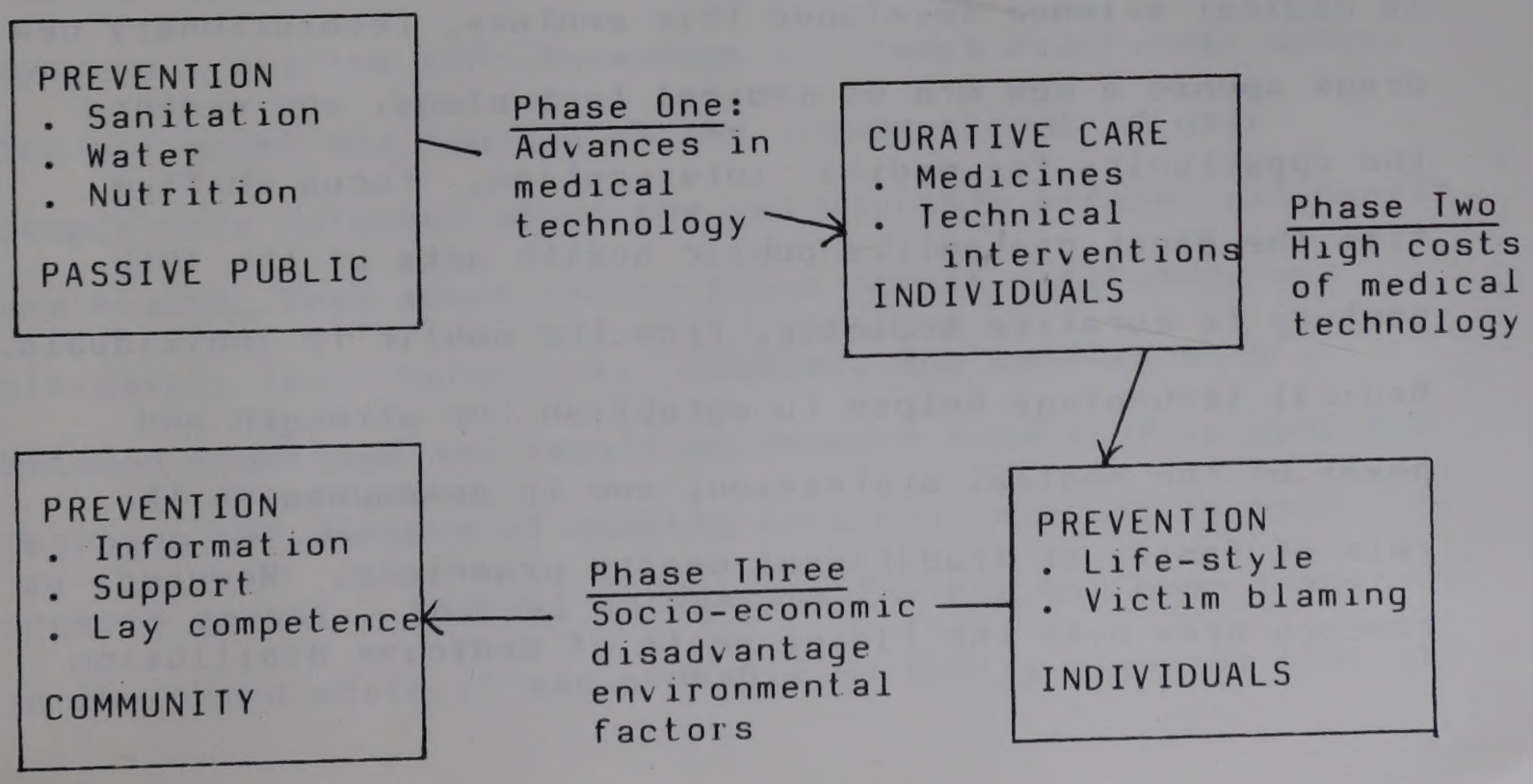
By the end of this century over half the world's population will be living in urban areas. Even in the least urbanized continent - sub-saharan Africa - nearly 40 percent of the population will be urban (Rossi-Espagnet, 1982). This has important implications for health education. Although most developing countries have different patterns of morbidity and mortality from the industrialized world, with increasing urbanization many are exhibiting both patterns typical of the first world (in the cities) and patterns typical of the third world (in the countryside). It is thus sadly true that many of the concerns of health education in the industrialized world are mirrored in the third world: smoking, alcohol and other drug abuse, sexually-transmitted diseases, health hazards at work, are all common pre-occupations. Added to these, third world countries are faced with the multitude of health problems caused by poor or inadequate sanitation and nutrition.

While most governments express great interest in developing health education services, there is often a gap between policy intent and implementation. Expressed concern is not followed up by sustained financial or other support. Few governments spend even 0.5 percent of their health budgets on health education (Moarefi 1981). Indeed, many would argue that much government passivity is compounded by contradictory policies. The obvious examples are alcohol and tobacco taxes, from which many governments receive large

revenues, a tiny proportion of which they then spend on publicising the dangers of over-consumption of alcohol and cigarettes.

Pessimism must not rule the day however. Although there are contradictions and constraints in health education there are signs of change. The impetus given to primary health care is leading to a re-kindling of interest in health education. It is the first of the core elements that make up the primary health care (PHC) approach, and of course PHC is being strenuously promoted by the World Health Organization, UNICEF and other international agencies. Also, ideas about health are changing making it a challenge to many outside the professional health education field.

In order to devise strategies to take advantage of the renewed interest in health education, it is helpful to trace the background to changing ideas. The pendulum has swung from preventive measures in the nineteenth century to curative care back to prevention, and from a passive public to individuals and back again to an active community this century. The diagram below shows this clearly.



## Changing ideas in health education

### Phase One:

The great preventive health moves made in the industrial world in the last century were directed largely towards improving sanitary conditions, but did not involve people in direct action. Edwin Chadwick, for example, the pioneer in sanitation and water supply systems in Britain, invested a great deal of effort in creating an informed public. His constituency was made up of politicians, administrators, professional experts and middle class people in general. Through diffusion of information to these sorts of people, who recognized that cholera or typhoid epidemics were no respectors of class, much public health legislation was passed in the cities and towns of Europe. Some of this knowledge was exported to the settler towns in the colonies, although their boundaries were much more limited. The public in general, however, was passive: there was no community participation in the laying of public waterpipes or sewerage systems.

### Phase Two:

As medical science developed this century, revolutionary new drugs opened a new era of medical technology, and widened the opportunity for medical intervention. Focus shifted from the great preventive public health acts of the 19th century to curative medicine, from the public to individuals. Medical technology helped to establish the strength and power of the medical profession, and to de-emphasise the role of family or traditional health practices. However, as concern grew over the rising costs of medicine disillusion

set in about its effects. Technical solutions were not always the answer. Indeed, many people, such as Illich, suggested that many medical interventions caused disbenefits. (Illich 1975) Thus while the focus in health education remained on individuals, concern shifted once more back to prevention, rather than cure. This took on a specific importance when the major causes of death in industrialised countries like Canada were characterized as 'self-inflicted' (Lalonde, 1974). While noting the importance of environmental effects on health (pollution, occupational hazards and so on) what was often picked out by Ministry of Health policy-makers was the role of individual responsibility. The claim was that people were smoking, drinking and eating too much of the wrong sort of food, and they were exercising too little (DHSS, 1976). 'Victim-blaming' became the order of the day, since the stress was on individuals to alter their routine behaviour and be healthier. In the third world victim-blaming was even more pointed: it was the women who gave the wrong food to their infants, weaned them incorrectly, did not boil water or protect food from flies.

The favoured health education method to change people's behaviour was the KAP (Knowledge Attitudes Practices) model. The KAP model was founded on the argument that if only people were informed about the relationship between ill-health and health, they would change their health attitudes, and ultimately their behaviour. However, the relationship between knowledge and resulting changed behaviour is complex: learning the dangers of smoking does not necessarily make smokers desist. Initial enthusiasm for KAP has been tempered. In the third world it was probably on family planning that it

foundered. The enthusiasm engendered by the technological breakthrough of the oral contraceptive led to a somewhat naive assumption that once women understood they could control their own fertility they would do so, and birth rates would fall. A great deal of financial support was given to countries adopting family planning programmes in the 1960's, and it was only later that social scientists took a critical look at motivation for family planning, at the methods used for instilling motivation, and suggested that the psycho-social relationship between fertility and contraception was a great deal more complex than much health education on family planning had implied (Bicknell and Walsh 1977).

The KAP model was also criticised on the grounds that it blamed individuals for things they could not always control. In the late 1970's this became a strong critique, the pendulum swinging away from individuals towards the community.

Phase Three:

The move away from individuals was affected by the revival of the debate about the causation of ill-health and the recognition that socio-economic disadvantage contributes enormously to both morbidity and mortality. Many people, it was argued, had few choices, a factor which victim-blaming ignored. If change was to come about, the focus would have to be on communities as well as individuals. Instead of ascribing culpability to individuals, it was to the 'manufacturers of illness' that attention should be directed. In other words, instead of blaming people for eating the

wrong foods, or giving their babies powdered milk in bottles, or on relying on too many drugs, the focus should be on manufacturers who were more concerned about profit than quality, on sales rather than ethics (McKinlay, 1975). In the less developed countries it was increasingly argued that government control of extravagant advertising by tobacco companies would be more likely to stem cigarette consumption than would exhortation to stop smoking by health educators.

As road accidents increase in third world countries, as local food is replaced by synthetic, perhaps imported 'convenience' food, as cigarette consumption rises with increasingly aggressive advertising and promotion by tobacco companies so many less developed countries need to move towards promotive community health education. Indeed, a WHO publication has challenged these countries to think about 'primordial' prevention, aimed at presenting the emergence and entrenchment of social, economic and cultural patterns of living that are known to contribute to elevated risk factor distributions (especially coronary heart disease) in developed countries (WHO 1982). A recent Lancet editorial observed "Increased promotion of cigarette smoking by the large British and American tobacco companies in the face of falling consumption at home is a sinister development in many African countries. Extravagent advertising associating smoking with sexual appeal and business success and lacking any health warnings is leading to a rise in cigarette consumption; in Kenya it is said to be growing by 8 percent a year" (Lancet 1984). The problem is not limited to Africa. From Egypt to Taiwan, cigarette brands boast names like "New Paradise", "Champion", "Long Life" and "Sportsman" (Royal College of Physicians 1983).

Examples of 'primordial' preventive action would be national government policies on nutrition, or on smoking control, in co-ordination with the food and tobacco industries, import, export agriculture and education sectors, and the media. The Sudan government for instance, has banned all tobacco advertising and sponsorship and prohibits smoking in closed public places. Other countries have prohibited the advertisement of dried baby milks. Action often involves legislation.

The swing towards community responsibility has been accompanied by the growing interest in promoting self-reliance. The shift is away from a medicalized view of health towards an interest in lay competence (Kickbusch, 1981). Where health education has traditionally been the regard of public health inspectors or a few doctors with special interests, the emphasis was on disease control and prevention, the accepted purview of the medical profession. However with changing disease patterns, social expectations and technology, the frame of reference has moved away from professional control to recognizing alternative non-professional resources and skills within communities.

These range from self-care at familial level to mutual aid groups which support and help members who may be similarly handicapped, disabled or chronically sick or who simply wish to increase self-reliance and decrease dependence on professional interventions. There is substantial evidence that social networks such as self-help groups, pressure groups, relatives and friends play an important part in keeping people healthy.

Thus the recognition of lay competence in health education is important. It helps people appreciate the health skills they already possess; it offers additional options useful in promoting health, preventing disease, treating minor illnesses and injuries, managing long term illnesses, and restoring health; and it helps to improve people's use of professional resources (Levin, 1982).

While this shift towards lay competence is more obvious in industrialized countries, there are many examples in less developed countries. The self-help Buddhist organization, Sarvodaya, in Sri Lanka, is an example, the Consumers' Association of Penang, another.

In this rapid review of the changing situation within health education, the pendulum effect is clear: from a passive public and a focus on prevention, to an emphasis on individuals and curative and later preventive measures, and finally swinging back towards community involvement, and prevention. Health education has moved from <u>information</u> - distributing posters and pamphlets, lecturing to passive audiences on radio or in schools or clinics, towards an <u>educational</u> role in which people work towards changing behaviour by understanding and learning about their own social environment. The last stage has been a move towards health <u>promotion</u>, where groups campaign for better health by changing their environment through political, social and economic pressures, as well as by promoting a sense of well-being.

Community health education is thus a complex concept that has arisen out of a focus on communities rather than individuals, an emphasis on participation and involvement, and a desire to promote preventive health action. This may occur at local and national levels; it may be aimed at helping change people's behaviour, or at legislative change. It is an approach to health education that has been paralleled in other fields like adult education where the emphasis has switched from individual group learning, to mass literacy campaigns using Freire's ideas about communication as a tool. In its widest sense community health education is not separate from development; without development, improvements in health are limited. Looking ahead, however, it is clear that attention in health education must be directed towards community activities, promoting policy changes at national levels as well as involving local groups in the promotion of better health. "We need to increase both the ability of people to take maximum power over their individual lives and their ability to change the social relations and structures in which they live and work. This is an important and feasible role for health educators" (Brown and Margo 1978).

## Strategies for community health education

Many people may be involved in health education. Their priority activities and the sort of strategies or techniques they use will reflect their own 'central interests' and their own perceptions about the causation of ill-health.

Sociologists, for example, may be centrally concerned with what they define as social problems, and therefore focus on

particular deviant or marginal groups. Psychologists in their emphasis of inter-personal relations or problems of self-esteem may prefer to use therapeutic methods with individuals or families. Doctors who see disease as a pathological process, may stress the importance of disease control and the utilization of health services. In the table below are a number of different models of health not necessarily mutually exclusive nor conceptually distinct in everyday life, but which give an idea of how someone's view of how ill-health occurs and their own central interest may affect both their priorities for action and the methods used in health education.

MODEL OF HEALTH (1)

| MODEL | CENTRAL INTEREST/ CAUSATION OF ILL-HEALTH | STRATEGY (examples) |
|---|---|---|
| 1) Medical | Pathology of disease | Mass media campaigns to inform and improve utilization of health services. |
| 2) Sociological | Social problems | Community development or special group programmes (eg. juvenile delinquents, single mothers) |
| 3) Psychological | Inter-personal relations poor | Group or individual therapy |
| 4) Ecological | Environmental problems | Pressure groups on pollution or need for water supply; legislation, consumer groups |

(1) Adapted from A Burkitt and J Jones in: Whither health education? Report from a conference, Health Education Bureau, Dublin, 1980. Pp 60-3.

| | | | |
|---|---|---|---|
| 5) | Traditional | Imbalances in living | Raising awareness about alternatives to medical care, promoting well-being. |
| 6) | Political-economy | Social and economic relations | Campaigning against or monitoring the activities of multi-nationals, industrial enterprises. |

Although many different people and organisations may be involved in health education, most countries have special units in their Ministries of Health which have responsibility for national health education programmes. Such units are usually small, relatively weak, and not financially well-supported (Walt & Constantinides 1982). Almost all health education units therefore experience a number of administrative and logistic constraints in devising community health education programmes. The national language of the country may not be common to everyone, communications infrastructures may be poor, specialized personnel are almost inevitably few. Each health education unit has to choose from a number of priorities for action, and adapt methods that are both feasible and relevant. No one method or medium is best, most being as effective as they are appropriately applied. From his experience in Africa, for example, Fuglesang reminds professionals of the rich oral traditions of many societies: "We judge people on how they express themselves in a secondary language like English or French, and we do not realise that village people and particularly the elders are usually highly vocal, witty and sophisticated in their speech..." (Fuglesang, 1981). Health educators need to be sensitive to communities and use the many untapped resources

and skills within those communities (Minnet, 1978). They may act as initiators, helping communities to identify their problems and what actions to take to tackle them, or as facilitators, helping communities or groups promote their own health through ways they have identified. These may range from small-scale village projects, to attempts to introduce legislative change.

There are many different methods to community health education. Having decided on priority activities health educators have to choose the most appropriate methods.

| | | |
|---|---|---|
| Working with people | : | public meetings and lectures<br>group discussions<br>drama, including role playing<br>demonstrations to groups<br>home visits |
| Working with mass media | : | radio, including listening groups<br>television, and video including viewing groups<br>newspapers<br>films, including video<br>theatre<br>wall newspapers, billboards |
| Working with visual aids | : | leaflets<br>films<br>slides<br>flannelgraphs<br>flipcharts, etc |

All these methods have advantages and disadvantages. For example group discussions may be effective in identifying problems or deciding action but need skillful direction to stop particular people from dominating, and to keep the issue in focus. Active participation by people through drama may be a useful way of 'learning by doing', especially where indigenous or folk methods are used. However, it is perhaps the mass media, especially radio and television, that are particularly seductive to health educators. They are glamorous and modern. In many less developed countries

they are precisely what foreign aid donors like to give, and industrialized countries to sell. Mass media also have the enormous potential advantage of reaching very large numbers of people. It is worth looking at this medium in more detail.

## Using the mass media

Like all other methods of community health education, there are many fallacious ideas about equating the effectiveness of health education with the quality and quantity of advanced technology available (Green, 1979). Experience in the Western industrialized world and a few third world countries suggests that using mass media to change people's health behaviour is often disappointing. The reasons for this are extremely complex. Some claim that inappropriate comparisons have been made with commercial advertising (Tones, 1981). Others that preventive medicine and health education have a relatively low status and their messages are therefore more likely to be accepted if presented by a high-status physician in an individual interview rather than over radio or television (Bunnag, 1981). Most communication theorists argue that the opportunity for dialogue is the *sine qua non* of effective communication, and mass media do not usually allow for this. The theoretical debate on the effects of the media on people's behaviour is complex however (Flay, 1981) and not considered here. What is increasingly accepted is that if the mass media have any influence on their own it tends to be in the direction of reinforcing existing beliefs and opinions, rather than in

changing or converting them (McCron and Budd, 1979). Although many less developed countries now have television as well as radio, it is often confined to the cities, which may leave out a substantial proportion of inhabitants. Radio promises to reach more people. Even here there are a number of technological difficulties that limit coverage by radio. Under-developed infrastructures may mean transmission and reception is imperfect. The production of radios and distribution networks may not be equal to meeting demand for radios or batteries. Multi-lingual countries cannot always satisfy all sectors of the population and often the majority of programmes are in the national (urban) language which is not common to all. Financial constraints exist in many countries which still import radios or some of the materials to make them.

## The communication process

In terms of communications there are other problems. One major constraint of radio is the impermanence of the message. If the recipient cannot keep pace with what is being broadcast, the message is lost. The radio broadcaster cannot even know if it has been received, let alone understood. The process of communicating - from communicator to message to recipient - is complex, and most health educators argue that one-to-one, face-to-face communication is the nearest a communicator can come to being certain that the message is understood and accepted. It is an inter-active relationship. Even then there are many pitfalls. Recipients may pretend to understand; may think that they understand; may understand but not

agree; may understand and agree, but not always change their behaviour.

How much more difficult then, to ensure that in mass communication messages are understood and well-received, let alone acted upon. Furthermore radio (or television) is not received in isolation. It is beamed into a social setting - a family house, a bar or cafe, school, or a public square. In all these situations there are individuals with existing beliefs and values, and to whom friends, family, work mates, teachers are all important sources of information who may influence attitudes and behaviour. People are not passive recipients in the communication process. Nor do people have equal access to media. Low status may exclude certain groups like women and children from listening to what is a highly-prized consumer item. As McCron says, there is no reason to suppose that the mass media are a particularly effective communication source. The messages received"... may reinforce those obtained from primary groups, but they may equally contradict them. Primary group contacts serve to mediate or filter mass-communicated messages" (McCron and Budd, 1979). In other words, people are active participants in a communication exchange which selects and interprets from the message in line with their existing knowledge and predispositions.

It thus becomes clear that health education messages, produced nationally in urban centres, however factual or right-minded, may be unacceptable or of little consequence to rural people. The colonial experience has left many

countries with heavily urban-biased media, and even where there is a desire to extend broadcasts to rural areas, professionals are hampered by their own attitudes and orientations (Commonwealth Committee 1980).

How effective are mass media?

In spite of its constraints radio remains enormously attractive because of its relative efficiency and cheapness in reaching large audiences. Many health educators believe in it, and indeed, use it in a number of ways, for short health education talks, doctor's forums, quizzes, and sometimes drama with a health message. However, there has been little evaluation of its effectiveness. One review of health and nutrition projects using mass media techniques concluded that there is almost no evidence concerning the impact of mass media health and nutrition projects on the health status of the target audience (Leslie, 1981).

This is partly because it is extremely difficult to evaluate the effectiveness of health education projects. Few measures get beyond counting the number of radio transmissions made or the number of people contacted. A few projects have tried to test before and after the project to measure changes in attitudes or knowledge, but measuring a change in behaviour is methodologically much more difficult.

In another assessment of a number of health education projects using the media (Jenkins, 1982) the conclusion is that media in health education will have most impact where media projects are integrated with health services. An

educational effort divorced from such support is relatively ineffective. Furthermore, using media alone to project health messages, is very unlikely to lead to a change in behaviour. Media can more effectively be used by providing an atmosphere in which changes can take place, or to provide reinforcement once change has occurred. In gathering together her evidence, Jenkins says that radio emerges as the most useful of all media, reaching as it does large audiences including illiterate people, providing that broadcasts are made in appropriate languages. Television remains a realistic medium for very few developing countries. It is far more expensive than radio, and there is little difference in the effects or functions of the two. "The one difference is that television acts like a magnet; once it is there people watch it." Cassettes have the advantage that they can be replayed, the technology is relatively simple, and where equipment is available they can be used to enable community participation in production. Finally, Jenkins comes down firmly on the side of printed materials. "Although radio comes across...as the dominant medium...print is by far the most important and extensively used medium of instruction; it is less glamorous than broadcasts and its use is consistently under-reported." This is perhaps a more controversial point: in many illiterate societies the importance of story-telling may outweigh the value of visual material, whether in pictures or words.

However, in deciding which method to use it is pertinent to quote Fuglesang. "It is nonsense to ask 'which medium is best'? The important thing is the message design, the

development of a 'people's language' which can be used in any available medium" (Fuglesang, 1981). The effectiveness of any method depends on its appropriateness.

## Conclusions

This introduction has explored the concept of community health education, putting it in its historical context, and showing how it has evolved from a rather narrow public health concern with individuals, to a much broader understanding of the interaction of individuals with their environment: how it has moved from health information to health promotion. Different approaches to community health education, with special emphasis on the role of the mass media, have also been discussed. In conclusion, what are the future policy implications for community health education?

"Education concerning prevailing health problems and the methods of preventing and controlling them" is listed as the first of the eight essential activities for primary health care (PHC) by the World Health Organization. The primary health care approach which is seen by the WHO as the strategy for achieving health for all by the year 2000, is being strongly promoted throughout the world, and most countries are signatories to its objectives. Fundamental to the primary health care approach is the participation of communities in the control of their own health. Community health education thus is an important part of primary health care.

However, the gap between support for PHC and implementation

is large. Similarly the reality is that many governments do not make health education a priority. There are complex political and planning reasons for this. Governments are often ambivalent about health education. For example, large amounts of tax revenues are obtained from the sale of such products as tobacco and alcohol. They may be very reluctant to enter into conflict with industry, since the revenue from these sources is substantial and easily come by. A few governments have negotiated with the tobacco industry for example, and won concessions such as the warning "Smoking may damage your health" that appears by law on all cigarette packets. They have sometimes banned the advertising of cigarettes or of tinned baby milks, or controlled the form advertising can take, but these measures are considered by many to be partial and relatively ineffective. Real conflict may thus be raised between health educators, who are state employees, and governments who are ambivalent about challenging industry. Such conflict may be more severe where cause and effect is less accepted or more difficult to establish - in hazardous work conditions for instance. Health educators within Ministries of Health may feel constrained in the sort of health education action they can undertake, and may play safe by concentrating on less political issues, leaving to non-government organizations or community groups the active lobbying for legislative change.

Many of the planning difficulties in the promotion of community health education have been touched on. Centrally organized health education units in Ministries of Health leave little room for local decision-making or even local

culture or language. Radio may reach everywhere, but its message is urban-oriented and thus limited. It is more difficult to organize appropriate health strategies which involve the community but which then take time and patience, than to organize country-wide health messages on the radio, or to print thousands of leaflets about breast-feeding. De-centralizing activities, local control, consultation with communities, all so essential to community health education, are not often encouraged by governments.

To recognize the difficulties, however, is half way to doing something about them. To make community health education effective, some general conclusions can be suggested:

- priority should be given to local efforts - local communities should determine their own actions;
- community health education activities should be integrated with health services to ensure continuity and effectiveness;
- community health education activities must be carried out in the broad context of promotion as well as other community activities: this means campaigning at national levels as well as with local communities and with individuals;
- different professional disciplines should be involved in community health education: sociologists, psychologists, environmentalists, lawyers and others may all make useful contributions;
- although mass media have their place, too much reliance on technology is not effective.

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## A. DEVELOPMENT IN COMMUNITY HEALTH EDUCATION

In this section we explore the development of some of the conceptual approaches to community health education, the planning and implementation of health education programmes and the different methodologies used. Looking through the published literature it is clear that ideas about community health education have changed in the last decade, and the emphasis on primary health care is itself making different demands on health education. This is seen not only in the broadening of the concept, with the community becoming the focal point, but also in thinking about what constitutes community health education.

Much has been learned about planning and implementing programmes, and there is an increasing call for more evaluation. Manuals and guidelines suggesting models for those embarking on new programmes abound, with the caveat that each local situation has its own specific demands. Involving people in planning and decision-making at community level is increasingly recommended although the mechanisms for so doing, and examples of practice are less forthcoming. There is more emphasis on health promotion by legislative change or by trying to influence top decision-makers.

There have been many developments in the use of different technologies to put over messages. The sometimes disappointing effects of TV have led to a reassessment of the language and techniques of communication. The last decade has seen renewed interest in culturally relevant, simple tools for relaying ideas. And although radio and TV remain attractive media, indigenous drama, story-telling and shadow puppets are being used more and more to involve communities.

Another new approach is that of social marketing, which borrows communication and education techniques from commercial marketing. It has been tried in a number of countries, and is being strongly promoted by UNICEF. (See Section F: 1985 update on page 72).

## A. DEVELOPMENT IN COMMUNITY HEALTH EDUCATION

Abell H.C., Coleman W.F., Opoku A.A. 1968.
An African experiment in radio forums for rural development. Ghana 1964/1965. UNESCO: Reports and Papers on Mass Communication No. 51. Paris.

This paper reports on the setting up, organisation and evaluation of a Farm Radio Forum project in rural Ghana. Though the project had only a small health education component (nutrition) its methods, techniques and some of the recommendations have wider application in the general area of adult education in rural areas using radio. Evaluation points especially to the need for involvement and co-operation across all the relevant ministries if organisational problems in such projects are to be overcome.

American Public Health Association, 1982.
Primary Health Care Issues: Using Radio. APHA, Series 1, No. 1. 56 pages.

This is a general introduction to the use of radio in primary health care, both for getting over particular health messages, and for keeping in touch with health workers, working in isolated areas. The main body of the text presents guidelines for developing projects using radio for health education. There are short descriptions of 47 projects using open broadcasts, listening groups, special campaigns and tape recorders, in a variety of less developed countries, plus a bibliography. This is a valuable resource for countries in which radios are common.

Bailey J. and Cabrera E. 1980.
Radio Campaigns and Family Planning in Colombia 1971-1974.
Bulletin of the Pan American Organization 14(2): 126-134

The purpose of this paper is to describe the methods used to evaluate the impact of 3 radio campaigns aimed at attracting women to family planning clinics in 14 Colombian cities. The evaluation was difficult, but observers concluded that the campaigns helped to legitimize family planning. However friends, relatives and neighbours were still the main source of information about family planning, with radio second most important during the radio campaigns. When the radio campaigns were not in operation, health personnel rather than radio, were the second most important source of information.

Bassey Williams P. 1980.
The Need for a Comprehensive Health Education Programme In Nigeria. Royal Society of Health Journal 100(3): 90-94.

Guidelines are proposed with a list of eight priorities for a health education programme relevant for other countries as well as Nigeria. Particular emphasis is laid on co-operative programmes especially between the Ministries of Education and Health. The eight suggested priorities are:

> Increased emphasis on health maintenance and disease prevention; effective academic training for health educators; establishment of a School/Community Health Education Advisory Committee including professional, voluntary and lay personnel; co-operation of Health and Education ministries in a comprehensive health education programme; cohesive, interrelated and continuing "health learning experiences" for students and community in general; in-service health education programmes for teachers, administrators and Civil Servants in general; establishment of a nationwide school health programme at elementary and secondary level; establishment of health - resource training centres throughout the country.

This is a useful and hard-hitting article which criticises the increasing shift away from preventive towards curative medicine which has characterised the Nigerian health services.

Byram M., Kuate C.B., Matenge K. 1980.
Botswana Takes a Participatory Approach to Mass Media Educational Campaign. Development Communication Report No. 32 Oct 6-8. Clearinghouse on Development Communication.

A useful review of the successes and shortcomings of a radio learning group campaign in Botswana. In this instance the theme was 'Understanding Government'. The technique could be useful for health education in scattered rural settlements. The objective was to obtain villagers' views and opinions on various aspects of government policy and practice. A similar campaign in 1976 on tribal grazing land, had been quite successful as a consultative tool. In all 250 radio listening groups involving some 3000 or so people were established, resulting in a definite increase in people's knowledge and awareness of government.

Cassirer H. 1974.
Mass Media in an African Context. UNESCO: Reports and Papers on Mass Communication. No. 69 Paris

This is a final report and evaluation of the UNESCO/SENEGAL pilot project for the production, utilization and evaluation of audio-visual media and materials, including radio and television, for adult education. It provides an overview of the project involving womens TV clubs and health issues

and evaluates rural educational radio programmes, coupled with organized community listening and feedback to the station. The conclusions provide useful general pointers for this type of exercise. See also: Fougeyrollas P. 1967. Television and the social education of women UNESCO : Reports and Papers on Mass Communication No. 50 Paris, for a more detailed look at the organization of the television clubs for illiterate urban women.

Clarke W.D. 1980.
The innovation and implementation of appropriate health education. Proceedings of the Royal Society, London. B209: 141-145

The author argues that it is frequently assumed that effective appropriate health education for developing countries is simply a matter of finding out what the community needs and then delivering it. In discussing innovation in health education, he looks at the problem area of education versus communication. Education is too narrow, training having fallen into disrepute because it implies "getting subjects to do something without thinking or even against their will". He also looks at visual versus auditory channels in communication suggesting the latter has been neglected.

Dodds T.A. 1972. Multi-Media Approaches to Rural Education. Broadsheet on Distance Learning No. 1. International Extension College, Cambridge.

A useful overview (up to 1972) of a variety of uses of the media, especially radio, film and TV, in rural education programmes. The emphasis is on adult literacy and farming programmes, but the introduction deals with the overall role of education in rural development, the problems of rural education, and the potential of distance learning and the mass media. The author makes the point that while the mass media can fill a vital gap they cannot easily provide for feedback and local sensitivity. A combination of mass media and face-to-face methods is likely to be most effective.

Edwards N. 1981. The role of drama in primary health care. Educational Broadcasting International. June: 85-9.

This is an interesting account of how drama was used in Bumpe Chiefdom, Sierra Leone, in an effort to enhance the possible effects of health education on the development process. The author points out how traditional art forms like story telling or drama have a strong attraction for many people. Parables and fables are common forms of communicating. Yet formal education methods ignore such methods of communication. Community health nursing students in this area were encouraged to learn and to communicate

through drama. They made up three dramas with themes like neo-natal tetanus, tuberculosis, and feeding practices. Not only did they enjoy using drama to get ideas over, but they were also naturally good at it. The results have been very positive, with large audiences attracted when the student nurses visit villages. A useful and well-written article.

Feuerstein M.T. 1974.
A Comprehensive Community Approach to Rural Health Problems in Developing Countries. Community Development Journal. : 174-182.

A summary of the essential characteristics of a comprehensive community approach, some of which might be challenged. It looks at national development plans, community participation, community specificity in regard to customs, appropriate technology and health workers, self help and the role of women. See also, by the same author, Participatory evaluation : by, with and for the people in : Reading Rural Development Centre Bulletin, 14, 1982; 18-23, which explores the meaning of participatory evaluation and outlines some examples carried out in Kenya, the Philipines, Tanzania, Honduras and India. This is an extremely useful article, which blends well some of the theoretical problems of evaluating projects with the people, with practical case study examples.

Futagami S. et al. 1981.
The Educational Use of Mass Media Staff Working Paper 491. 124 pages. The World Bank 1818, H St., NW Washington.

The role of mass media in public health campaigns has become a subject of much debate. Although attitudes may be changed through increased or improved knowledge, behaviour does not necessarily change. However commercial use of mass media is not doubted. This paper asks why educators have not used the mass media to better avail to get over health messages.

Green L.W. 1979.
National Policy in the Promotion of Health. International Journal of Health Education. 22(3): 161-168.

The author examines the paradoxes which confront governments in policy-making and produces some models in health promotion which help identify these factors, issues and needs involved in policy. Strong emphasis is put on the need to decentralize decision-making. "Information" says Green "can be centralized but education cannot". This leads him to a consideration of the role of mass media, some reasons for its failure as a tool of health education, and its potential as an untapped source for health education," not in changing people's behaviour, but more likely in reinforcing and supporting behaviour that is being changed through more decentralized local processses of decision-making and change". A useful overview.

Green L.W., Kreuter M.W., Deeds S.G., Partridge, K.B., 1980.
Health Educational Planning: A Diagnostic Approach, Mayfield, California 306 pages.

This is an essentially practical book for health educators, which takes as its definition of health education "any combination of learning experiences designed to facilitate voluntary adaptions of behaviour conducive to health". The authors propose a model called PRECEDE" a tool to use intelligently in drawing on and applying the most appropriate scientific theories and educational technologies in planning effective health education." It helps health educators diagnose the problem, and uses the concepts of predisposing factors and reinforcing factors to plan health education's programmes. It is a book many will find useful. It goes through the model in simple stages, with exercises and examples. There are diagrams to clarify the concepts. While it is particularly oriented to North America, there is no reason why the basic model should not be used elsewhere. Theoretical but stimulating.

Hall B.L. 1978.
Mtu Ni Afya: Tanzania's Health Campaign. Information Bulletin No. 9. Clearinghouse on Development Communication (A.I.D.) Washington. 74 pages.

A thorough review of Tanzania's 'Man is Health' radio study-group campaign with good factual data and analysis of strengths and weaknesses. A useful introduction reviews the use of radio farm forums in India and Ghana and mass campaigns in Cuba and China. The body of the text concentrates on the organization and planning of the campaign, the training of study group leaders, how the study groups were set up and who participated. Three final chapters assess the impact of the campaign and its place in the development process. A thoughtful and vivid account of an interesting national (and therefore rare) programme.

Hellberg H. 1980.
Government attitudes to health education: a crucial factor in effective action, International Journal of Health Education. 23(2): 76-81.

The author argues strongly that it is a government's responsibility to provide an administrative and legislative framework, supportive of community action, through individuals and groups, in the area of health education. Governments should recognise and facilitate the role of voluntary agencies; share information about health and the health consequences of certain practices and behaviours and accept financial responsibility in developing a policy for health promotion. Unfortunately few governments have supported policy statements about the value of health education with such comprehensive action.

Jenkins J. 1983.
Mass Media for Health Education. International Extension College, Cambridge. 67 pages.

This book is aimed at people in developing countries who are interested in health education using media. Written by an expert in distance or non-formal education, it is especially geared at health educators who want to find out more about educational methods. The book is therefore an introduction to methods which make use of media. One section is devoted to descriptions of projects around the world which are helpful in considering the arguments for and against using media for health education purposes. The other main section is a practical guide to implementing such programmes, which gives clear guidelines on the planning, production, organization and administration of possible projects. Essential reading for any health educator who wants to make the best possible use of media. Available from: 18 Brooklands Avenue, Cambridge, CB2 2HN.

Kickbusch, I. 1981.
Involvement in health: a social concept of health education. International Journal of Health Education. 24 (4): Supplement. 15 pages.

An excellent paper which sets out the health education thinking and present and future strategies in the European Region of WHO. The relevance of what the author has to say is not limited to Europe. She identifies four main conceptual reorientations in health education. They are a move from: health prescription to health promotion; individualistic behaviour modification to a systematic public health approach; medical orientation to recognition of lay competence, and from authoritarian health education to supportive health education. In line with these reorientations the three main programme areas of the European region are health promotion; preventative health education; supportive health education. This is a clear resume of how health education is changing.

Leathar D.S., Hastings G.B., and Davies J.K. (eds) 1981.
Health Education and the Media. Pergamon Press, Oxford. 561 pages.

This book contains the proceedings of a conference organized jointly by the Scottish Health Education Group and the Advertisin Research Unit, University of Strathclyde. Papers are organized into 3 main groups: theoretical issues; development of material evaluation. Many of the papers address themselves to health problems more common in the developed world: cigarette advertisin alcohol abuse, breast cancer screening, and tend to assume the availability of high-technology media means such as TV, video and Prestel. However the whole conference provides a useful overview of the media in health education. Delegates

agreed that the mass media's power to change behaviour had been overestimated. Campaigns that had worked well had done so because they were co-ordinated, they were backed up by self-help groups, and they had specific aims. The importance of political will in opposing anti-health advertising and commerce was stressed. There are some excellent contributions from Bunnag, Budd and McCron, and Tones among others.

McAnany E.G. and Mayo J.K. 1980.
Communication media in education for low-income countries: implications for planning. UNESCO: International Institute for Educational Planning, Paris. 77 pages.

This booklet attempts to provide an overview of the potential of educational technologies when correlated with specific policy objectives such as extending educational opportunity or developing rural areas. Much of the text is given over to four case studies, three involving radio learning and one, TV broadcasts. The first looks at distance-learning for rural youth in the Dominican Republic; the second at improving classroom mathematics in Nicaragua; the third at radio listening group campaigns in Tanzania including 'Man is Health' and 'Food is Life'; and the last at the Satellite Instructional TV Experiment (SITE) in India. Benefits and drawbacks are discussed, and a chapter devoted to examining the critical issues for planning the use of communication media in education is particularly useful. As far as the area of participation of the people in their own education is concerned, the authors raise some general doubts about the role of the mass media in education. They warn that "taken as a whole, the use of technology in education generally tends towards centralization and therefore limits people's control over their own education." The descriptions of the case studies make this a useful resource.

McCron R. and Budd J. 1979.
Mass Communication and Health Education. I. Sutherland (ed) Health Education: Perspectives and Choices. George Allen and Unwin, London. 199-218.

This is an important paper for those who are concerned with the nature, potential and limitations of mass media in health education. In an attempt to explain the relative failure of the media in health education to achieve its potential over the last 30 years, the authors review first the nature of the communication process itself and second that of the mass communication process with its additional technical constraints. They conclude that the case for the use of the mass media in health education is by no means as clear-cut or simple as might be supposed, especially as it relates to health campaigns. They point out that the mass media are only one among many sources of information, and that recipients are not passive, but select and interpret

from messages in line with existing knowledge and predispositions. "Instead of starting with a series of prescriptive campaigns which it is believed the audience will accept and act upon, considerably more attention needs to be given to an understanding of the issues from the perspective of the intended audience before a decision is made as to what the message should be and by what media and in what form it should be presented."

Meyer M., (ed) 1981.
Health Education by Television and Radio, K.G. Saur, Munich 476 pages.

Research papers, case studies, reports and background information on broadcasting and its usefulness in health education make up this excellent volume. The book is divided into six sections, the first looking at overall themes; the second explores different approaches and findings of communications research; the third is composed largely of case studies where health education has been used in development; the fourth is concerned with concepts and specific programmes, and the fifth looks at experience in co-operation between broadcasters and health educators. The last section contains a bibliography of nearly 200 references to health education and radio. The focus of the book is on industrialised countries although there are examples from the less developed world. See also: Health Education by Television and Radio. Report on the Conference held in Munich, Nov. 1980. Organised by the: Internationales Zentralinstitut fur das Jugend- und Bildungsfernsehen, Munich in co-operation with WHO, Geneva. The report outlines the objectives,organisation and proceedings of the Conference and summarises the reports of the working groups.

Minett, N. 1978.
Health Education: By whose Standards? Under what Circumstances? Unpublished paper available from CARE Inc., 660 First Ave, New York, N.Y. 10016. 13 pages.

This down-to-earth paper about health education is particularly focused on developing countries. Written clearly and simply, the message is that cultural differences between people must be taken into account when devising a programme of health education. The author gives the example of insisting mothers feed their sons eggs when they believe this will make them effeminate, and also raises questions about what cleanliness means in different societies. If such issues are not considered, health education will not be effective. The paper is full of useful examples of what sort of questions need to be asked and gives practical steps for health educators to follow.

Minkler M. and Cox K. 1980.
Creating Critical Consciousness in Health: Applications of Freire's Philosophy and Methods to the Health Care Setting. International Journal of Health Services. 10 (2): 311-322.

A revival of interest in health promotion and health education coupled with growing support for self-help and self-care movements, has led to a search for different methodologies in health education. The authors have looked outside the health care field to the ideas of Paulo Freire, the Brazilian educationalist, for a fresh approach to health education. They describe briefly Freire's philosophy on the development of critical consciousness (conscientizacion) and describe in detail two case studies of health promotion using Freire's methods. One was successful (among Honduran peasant women) and one was unsuccessful (among U.S. elderly poor). However, they demonstrate how, with relevant modification, Freire's philosophy and methods may be used to bring about major social change in the health field.

Moarefi A. 1981.
Some Considerations in the Health Education Component of Primary Health Care. Paper delivered at: All-Africa First Health Education Conference Lagos 31 Aug-5 Sept 1981. Available WHO Geneva.

The background to developments in health education during the past 40 years is given, analysing the support, decline and then renewed support for health education through the '40s, '50s and '60s. The author pinpoints family-planning programmes of the '60s as a turning point in health education which began to shift from the psychology of learning focused on materials and methods towards a more sociological, dynamic emphasis. Often the problem is not to change the attitude of people but the attitudes of the providers of health services. Health education should be considered as a tool to encourage the people to comply with plans already made. Its purpose should be to elicit the co-operation of the providers of health care in order to collaborate with people so that people may be empowered to make realistic plans and help them to implement these plans. Effective means of achieving this include higher priority for health education in health budgets and the development of central and provincial units of health education.

Moynihan M. and Mukherjee U. 1981.
Visual communication with Non-literates: A Review of Current Knowledge Including research in northern India International Journal of Health Education. 24, 4: 251-261.

A very interesting discussion on the importance of health education material being culturally based and tested locally. Many people cannot understand pictures and much thought has to be given the presentation of information. Thus, centralized development of materials by professionals,

especially in large and culturally diverse countries like India, is critized. The authors argue strongly that the pictoral content of health education materials has to be adapted to the region, where clothing, utensils and buildings vary. The authors have identified 14 concepts which convey all desired information to traditional midwives. For example the most popular sign for "good" was a parrot and for "danger" a snake. Working with the people to discover what is understandable and relevant is essential. A useful article particularly for those concerned in production of materials.

Ramadasmurthy V., Rao D.H., Clarence I.D., and Balasubramanian S.C. 1978. Nutrition Education and SITE Telecasts. International Journal of Health Education 21 (3): 168-173.

This evaluation of some selected nutrition-oriented telecasts transmitted under SITE (the Indian Satellite Instructional TV Experiment Programme) is a timely reminder of the need for thorough local information and planning preparation if high technology media is to be of any use in community health education. In this case the telecasts significantly failed to reach even a reasonable proportion of the target group, rural women of childbearing age, for fairly simple social reasons. The main one was that they were broadcast at a time when most women, having returned from the fields, were engaged in their cooking and domestic chores. The study highlighted the need for: Improved quality telecasts; greater research into the felt needs and social and work patterns of the target population and the development of a supportive/follow-up infrastructure based on face-to-face communication. See also: Ramadasmurthy V. 1979. Nutrition Education and Site Telecasts in Abstracts: 10th International Conference on Health Education.

Reading Rural Development Communications, 1982. Talknology rules? Bulletin 16. University of Reading, Agricultural Extension and Rural Development Centre, London Road, Reading RG1 5AQ, UK.

This is an excellent issue of a quarterly journal, which has much to interest health educators although its focus is general. Some of the most relevant articles are by Wake, Frazer and Kidd. Wake explores the role that dialogue can plan in participatory rural extension work, through an analysis of one element in the Indian SITE programme and another example from Dominica. Frazer neatly sums up the pros and cons of radio listening groups, and suggests that in countries where radio ownership is widespread, resources would be better utilized by producing really good broadcasting programmes. Participatory drama, popular analysis and other means of using 'theatre for development' are explored by Kidd in Botswana and Nigeria. The Bulletin ends up with a useful annotated bibliography and resources.

Richman L.A., Urban D. 1978. Health Education Through Television : some Theoretical Applications. International Journal of Health Education 21 (1): 46-52.

A simply written discussion of different theories relating the use of television and health education. For example, the authors talk about the diffusion theorists like Lionberger, Rogers and Shoemaker and Klapper who believe that mass media like TV can be used to increase awareness and arouse interest in an idea and even lead to changes in neutral or weakly held attitudes: but they conclude that generally interpersonal, face-to-face communications are required to modify strongly held ideas or achieve time behavioural changes. Useful for those interested in some of the theoretical discussion about the influence of mass media.

Rifkin S. 1981.
The Role of the Public in the Planning Management and Evaluation of Health Activities and Programmes, including Self-Care. Social Science and Medicine. I5A: 377-386.

Questions about public involvement in health issues are the focus of this paper. It looks at the question of whether lay people can contribute to a field that is as highly complex as medicine, then at the question of how suitable organizations can be created and maintained to sustain participation in health activities. Finally the author asks how can the public be motivated and mobilized to become involved in health activities. She suggests four approaches which have been used in talking about public participation. They are the public health approach,the health planning approach, the community development approach and the self-care approach. With each she traces the history of their origin, what each says about the questions asked initially, and what these views then imply about public participation. Worth reading because there are few discussions of the different meanings given to public participation, which is itself so germane to health education activities.

Scotney N. 1981.
We must Stop Ignoring Local Culture. World Health Forum 2(4) : 531-532.

Increased numbers of properly trained health education workers rooted in local culture and sympathetic to indigenous customs, attitudes and felt needs, have enormous potential in contributing to the development, improvement and extension of maternal and neonatal care services in the developing world. Culturally alien programmes, like many early family planning projects, ignored traditional and effective birth spacing customs in Africa. The author believes the touchstone in training lies in effective two way communication leading to the establishment of co-operative relationships between health education workers and the community they serve and between health education workers and the health staff providing the health services. Short but sensible viewpoint on health education.

Sheiham A. 1978.
Evaluating Health Education Programmes. The Health Education Journal. 37 (1): 127-131.

Health education officers constantly assess the programmes under their control though they may not call the process evaluation. They guage the rate of progress of a new programme, appraise personnel performance, estimate the effectiveness of a particular technique, look at other programmes and compare results. This routine day-by-day process may not suffice, particularly now in an era of accountability. The author reviews the current concepts about evaluation and suggests some guidelines which health education officers could apply. The article thus looks at types of evaluation, guidelines for evaluation, the goal-attainment model, the systems approach. Useful for those setting out to evaluate programmes for the first time.

Standard K and Kaplor A. 1983.
Health education : new tasks, new approaches. WHO Chronicle 37: 61-4.

The authors endorse the findings of a WHO Expert Committee on New Approaches to health education in primary health care, which stressed the need for a critical assessment of the many existing approaches to health education. They argue there are four target areas for new ideas. The first is identified as people-oriented technology, which respects the current conventional wisdom that people should be given the opportunity to play an active role in decisions regarding the kind of health technology they are to receive. The second emphasises the richness of lay resources. The third suggests health education must change from being prescriptive, 'telling people what to do', to taking a comprehensive view of the family within its social economic and political environment. And finally, these new attitudes will call on changes in roles for health educators and their training. They then try to enumerate the implications of these conceptual changes for health education practice.

Sutherland I. (Ed) 1979.
Health Education : Perspectives and Choices, George Allen and Unwin, London, 273 pages.

The book is made up of 12 individual contributions designed to cover a wide variety of aspects of health education each raising their own problems and posing their own questions. Though largely geared towards the industrial world, especially the U.K., several of the chapters have wider analytical and practical application. See, for example, the chapters by McCron and Budd and Tuckett.

Tonon M. 1978.
Models for Educational Interventions in Malnourished Populations. The American Journal of Clinical Nutrition 31 Dec. : 2279-2283.

A theoretical article which compares two models underlying community educational interventions. The first takes the rational empirical approach which is basically information oriented. An instruction method is given which is easy to plan for but shows little result in effecting change in developing countries. The second approach takes a normative re-education line. This requires an analysis of the target groups; a holistic approach; and full participation of the groups with the professionals at all stages of planning and implementation. It is harder to plan and carry out but more flexible and has a higher success rate. This second approach is therefore recommended for developed and developing countries.

Tuckett D. 1979.
Choices for Health Education: A Sociological View in Sutherland I. (Ed) Health Education: Perspectives and Choices. George Allen and Unwin, London, 39-63.

The author distinguishes three sets of reasons for health education. The first sees health education as a branch of preventive medicine, the goal being to produce changes in beliefs and behaviour in order to reduce mortality and morbidity. In the second health educators set themselves the task of helping people make effective use of existing health care resources. In the third the goal is to produce a general understanding of more diffuse health issues such as biological knowledge, sex and contraceptive education. These three sets of reasons define but also limit the present field of health education. They each raise difficult questions of value judgement and therefore of ethics and politics. The author then examines the limitations of the current conventional approach to health education in the U.K. with its emphasis on the modification of individual attitudes and behaviour and turns instead to a model where the main aim of health education would be a de-mystification of health care technology and an effort to encourage public participation in goal setting and evaluation at both an individual, clinical and social system level.

Wolfson J. and Bailey L. 1978.
A Community Education Approach to Health: The Open University. International Journal of Health Education 21 (4): 249-252.

This is an interesting account of how the Open University in Britain has developed two distance-learning courses on health education, transforming scientific and every day knowledge into functional learning materials, guided by the principles described. For example, they start with three basic tenets: one, life experiences are a starting point.

They have devised topics on issues such as "Am I pregnant?" "Why do babies cry?" "When parents disagree." The second principle is that course themes are learner-centred, not subject-centred. Thus for example, " motor development" is not mentioned but development in using hands and arms is discussed in relation to "dressing" "mealtimes" and so on. Finally, the third principle is that courses promote personal discovery, decision-making and skill development: the question asked is "what do we want to enable students to do?" and not "what do we want to tell them?" Methods used include texts, radio and T.V. programmes. Although liked by professionals and parents, the courses still only reach a minority of pre-school parents, and in particular, a minority of disadvantaged parents.

W.H.O. 1974.
Health Education: A Programme Review. Offset Publication 7: Geneva, 78 pages.

This report reviews WHO's work in the field of health education since the setting up of the health education unit within the Organisation in 1949. It covers health education in family health care, environmental health, communicable and non-communicable diseases, health manpower development and in school. There is also a chapter on priority needs and research for health education services. One annex contains practical examples of health education programmes in Panama, Nigeria, Philippines, Surinam and India, and there is a bibliography of over 100 references. It is a useful overview of WHO activity in health education up to the 1970's.

W.H.O. 1981.
WHO/UNICEF Regional Workshop on Information, Education and Communication on Health. Manila, Philippines 17-23 March. Available: Regional Office for the Western Pacific of WHO Manila, Philippines.

Final report of a five day meeting which dealt with the present state of, and future strategies for, information, education and communication in primary health care. The conference was expecially interested in the use of mass media in health education and the need for co-operation among various government departments responsible for relaying information to the public. Besides a brief summary of the meeting's discussions, there are country reports from Australia, China, the Cook Islands, Fiji, Guam, Hong Kong, Japan, Kiribati, Malaysia, New Zealand, Papua New Guinea, the Philippines, Singapore, the Solomon Islands, Tonga and the Marshall Islands. There are also five background papers which look at various aspects of primary health care, education and the media. See also: First WHO/UNICEF Regional Workshop on the Promotion of Health Information. Manila, Philippines 1979, which provided an overview of the current status of health information dissemination, again with a focus on the role of the media.

WHO, 1983.
New Approaches to Health Education in Primary Health Care. Report of a WHO Expert Committee. Technical Report Series, 690. Geneva. 44 pages.

The new approaches outlined in this report are characterized by an emphasis on the development of a people-oriented health technology at one level, and looking at the major influence of political, economic, cultural and environmental factors on health behaviour. There is also an important part which is devoted to training. The report should be of value to administrators and health workers as well as other sector workers, as WHO's latest views on health education.

## B. COMMUNITY RESOURCES IN HEALTH EDUCATION

All communities contain valuable resource persons who can mobilise others for health education activities. They may be school children or their teachers, students, itinerant medicine-men, or other folk practitioners like traditional midwives, village health committees, or the members of the many voluntary organizations that exist at local and national levels (Red Cross, Rotary, religious or church groups, consumer associations, women's clubs or groups are all examples). Participation in health education may be at the level of occasional campaigns or in more continuous activities like the child-to-child programme, or it may form part of the on-going decision-making process of village health committees. Harnessing the energy and spirit of the local community will give an important impetus to health education, and affect its acceptance and impact.

Much of the success of involving communities will depend on health educators capitalizing on existing motivation, recognizing local talents and drawing them in: but they will need support and to be integrated with local health services. Local community efforts will only succeed if they are matched with equal commitment from health education professionals and health services. Community activity at national levels (through consumer groups, for instance) is also important for initiating social reform and health legislation: health educators need to encourage such action for health promotion.

The annotations in this section reflect these different issues. They illustrate the multi-sectoral nature of much community health education, drawing in community resources from different areas. They give examples of the inputs that can be made through medicine-men, using popular theatre, community and religious groups, elementary school pupils, and primary health workers. They show how important is the support of health services and health education professionals in the continuity of health education activities.

Ariyaratne A.T. 1977.
A People's Movement for Self-reliance in Sri Lanka. Assignment Children, 39: 78-98.

A description by its President of the work of a non-political people's movement based on Buddist principles, founded in Sri Lanka in 1958. (The Sarvodaya Shramadana Movement) It involves more than 1200 villages and is the largest non-governmental organisation in the country. Several of its community-based activities have health educational aspects. See also Taylor in New Internationalist, 105; 25, 1981, for a brief more critical view of Sarvodaya's work.

Backheuser M.P., Kampel M.M., da Costa A.P. 1979.
A community health education program. Bulletin of the Pan American Organisation 13 (2): 124-130.

A community health education programme (PES) in Brazil operates by organizing local groups and encouraging them to discuss and attack health related community problems. It began in 1976, and during the first year the work performed by community groups included the construction of cesspools, purchase of filters, preparation of vegetable gardens, establishment of refuse dumps and so on. By mid-1977 PES had become fully operational and was active in 402 of Brazil's 3,953 counties. Community health education developed in individuals the capacity to think, compare, select, and use health information and methods geared to their particular needs, and secondly, provided individuals with at least the minimum store of concepts and attitudes needed to make them effectively self-reliant in health matters.

Bhalerao V.R. 1981.
Schoolchildren as health leaders in the family. World Health Forum 2 (2): 209-219.

An example of a co-operative health education project between a health care centre and a school, in the slums of Bombay. Starting with a free lunch programme at the school, clinic staff began systematically to educate the children in nutrition and personal hygiene in the expectation that the health messages would be relayed home. The author claims that not only did a healthy competition develop between mothers, in trying to meet their children's nutritional requirements, but there were peripheral benefits. For example school attendance increased to almost 100 percent. This initial success allowed the clinic to use the school children in a successful immunization programme of their siblings and as general monitors of health and hygiene in their families. Short but optimistic example.

Brieger W R. Adeniyi J, 1982
Urban community health education in Africa. International Quarterly of Community Health Education. 2; 109-121.

Urbanization is occurring fast in Nigeria. This study took place in Ibadan, a city of over one million people. As part of their training in health education, students at the African Regional Health Education Centre (ARHEC) spend at least two days a week in urban communities, working with those communities on problems they have identified. The paper describes the philosophy behind this approach, and gives a description of several projects undertaken over the years pinpointing their failures and successes. It is an excellent example of the pitfalls community health educators can fall into, and of the complexities of interaction. An assessment of community development rounds off what is a valuable contribution to the theory and practice of community health education.

Burghart R. 1982.
Health Education in South Asia: An 'Experiment' with Itinerant Medicine men. South Asia Research 2; 15-24.

The selling style and success rate of two itinerate medicine men is compared to see what lessons may be drawn for health educators. The author's main point is that little attention has been given to the mode by which the health educator gets across his message. The two itinerants sold a similar ayurvedic 'tonic' at the same temple forecourt (though at different times) to a similar audience of male peasant cultivators. The first salesman, who had low success rate, dressed as a traditional holy man and accompanied his instructional dialogue with demonstrations of a magical nature. The second salesman dressed as a civilian from the urban middle class accompanied his talk with old medical pull-out charts and had a high success rate in sales of his 'tonic'. Quite apart from the more persuasive powers of the second salesman, the author points out that clinical dress and pedagogic approach were important factors for the non-literate audience who were members of a stratified society and who placed high value on education. He concludes that health planners ought to pay attention to the social context in which health education messages are transmitted. The formal appearance of the educator, his rhetorical skills,and the mode of discourse are important factors in securing acceptance of the message.

Cripwell K.R. 1981.
Community health workers and the need for training in communication skills. Tropical Doctor 11 (2):86-8

Brief but useful article reviewing the role of community health workers in primary health care and their relative lack of success in the preventive and promotional aspects of health as versus the curative. The author suggests a thorough grounding in communication skills as part of community health workers training programme and suggests possible material: radio shows, used effectively in Nepal to improve farming methods; and story telling, drama, mime and dance used in Nigeria.

Feuerstein M.T. 1981.
Child-to-Child Evaluation Child-to-child programme:
Institute of Child Health, London, 47 pages plus appendices.

An evaluation and report on the working of the child-to-child programme. Launched initially in 1979 - the International Year of the Child - the concept was based on the reality common to many areas of the world - that older siblings often care for younger children while parents are working. They are involved in their nutrition and hygiene, and provide stimulation by talking and playing with them. In 1981 the child-to-child programme was evaluated, to determine, among other things, the origin and extent of child-to-child practice. Although the response rate from countries sent a questionnaire was not high, it was possible to get an idea of some activities. This report describes the evaluation, with more detailed outlines from Chile, India and the Sudan.

Isely R.B., Sanwogou L.L., Martin J.F. 1979.
Community organisation as an approach to health education in Rural Africa. International Journal of Health Education 22 3: 3-19

An account of the setting up of village health committees in south central Cameroon, with a discussion of methods used, activities and accomplishments of the committees in relation to latrine building, protected springs, garbage pits, and animal enclosures. The evaluation related only to numbers of activities undertaken (and not the impact on health attitudes, health-related behaviour or health status) and to some subjective assessments of the committees' work. The article is useful however, for its analytical approach, and the discussion at the end on the implication of such experiments for overall development could be very useful to many other countries, especially those in Africa. See also: Isely R.B. and Martin J.F. 1977. The Village Health Committee - Starting Point for Rural Development. WHO Chronicle, 31:307-315.

Kidd R. and Byram M. 1978.
Popular theatre as a tool for community education: four case studies from Botswana. Assignment Children, 44: 35-65.

An interesting look at participatory theatre as the starting point for educational programmes and as an accompaniment to on-going problem-solving by the communities involved. It has interesting potential for community health education, especially in its avoidance of leaving audience members as passive recipients of government messages. See also The Popular Performing Arts: Non-Formal Education and Social Change in the Third World. A bibliography and review essay by Ross Kidd, 1982. From: Centre for the Study of Education in Developing Countries (CESO), The Hague, Netherland. 127 pages.

King M.E. 1981.
The role of the skill-trained volunteer in international public health: Peace Corp's health programming and health policy in developing countries. American Journal of Public Health. 71 (4): 408-9.

A somewhat self-congratulatory article, but it does point out that the peace corps has for 19 years emphasized community-managed health care with good cost-effective results achieved on very limited budgets. It suggests a few way of integrating health education and health improvement with other "survival-enhancing" efforts.

Moynihan M. 1980.
Training folk practitioners as primary health workers in rural India. International Journal of Health Education. 23 (3): 167-178.

An estimated 40% of all sickness episodes are treated by village folk practitioners. Their role as healers and their potential as community health educators has been under consideration for the past decade or more. This paper reviews and evaluates four training programmes for folk practitioners, including traditional birth attendants. Teaching aids and methodologies used have wider applications. The authors note that because of their deeper knowledge of local customs and language paramedicals may be more successful in running such courses than doctors.

Rohde J.E. and Sadjamin T. 1980.
Elementary School Pupils as Health Educators: Role of School Health Programmes in Primary Health Care.
The Lancet, 1: 1350-2.

A health education programme involving school children in Indonesia. The authors designed a school health manual using a format familiar to primary school teachers. Forty nine lesssons covered 14 subjects such as diarrhoea, nutrition, accident prevention, skin care and dental health. The impact of these lessons on community health behaviour was surveyed by a 10% sample of families in 2 villages served by the 2 schools, asking questions on attitudes knowledge and practice regarding diarrhoea, both before pupils received that lesson and after. The result showed a substantial improvement in knowledge about prevention, appropriate treatment and the need for referral among both pupils and their families in the community. Interesting and worth reading.

Ross D.A. 1979.
The Village Health Committee - a Case Study of Community Participation from Sierra Leone: The Serabu Hospital Village Health Project. Contact 49 1-9. Christian Medical Commission. World Council of Churches. Geneva.

A clearly written-up project with evaluation techniques built-in at the early stages. It involves three villages (others to be added later) in the area of a church hospital. The main aim was to decrease the prevalence of disease by motivating the people to adopt practices which promote health. The method used was to encourage the liaison of village-selected village health committees with staff provided by the hospital as advisors/educators/participants in the village locus.

Saksena D.N. 1978.
Health Care and Education for Rural People: An Indian Experiment. International Journal of Health Education. 21 (4): 258-266.

This article reviews the evolution of the Indian Rural Health Scheme of 1977 to provide one community health worker per 1,000 rural population and describes an early study in Uttar Pradesh whose aims were to examine the socio-demographic background of a sample of trainee community health workers, their job motivations and reactions towards the training. The study revealed the need to streamline the selection procedure with health personnel and villagers working together to select suitable candidates; to examine ways of removing discontent among community health workers at the inadequacy of medicines supplied and the level of honorarium received; and to provide periodic refresher courses.

Schweser H. and Blaize A. 1976.
The Development of a Health Education Department in a Less Developed Caribbean Country. Project Hope, The People-to-People Health Foundation Inc., Washington D.C. 70 pages.

Following the 1973 Caribbean Health Ministers Conference, the decision was taken to set up a pilot program, establishing a Health Education Department where there had not previously been one. Antigua was chosen to host the program, and this report describes the steps taken to set up such a Department and to involve the public as well as all other relevant government departments and services. Full use was made of the media as introduction and back-up and strong emphasis placed on an integrated approach, with stress given to health education in schools. Appendices cover the materials and resources used as well as evaluation techniques applied. See also: Schweser H. A Manual for Community Health Education in the Caribbean Health Education in the Caribbean, Project Hope. 261 pages. and Schweser H. 1973. A Manual for Health Education in Botswana. Gabarone: Government Printing Office. Botswana.

Simoni J.J., Vargas L.A., and Casillas L. 1982.
Medicine Showmen and the Communication of Health Information in Mexico. Non-Formal Educational Information Center College of Education, Michigan State University East Lansing, Michigan, U.S.A. Occasional paper No. 7 18 pages.

An interesting use of traditional figures, Mexican medicine showmen - as community health educators. Five such showmen were trained to deliver standardised infant nutrition messages using their own showmanship style. Twelve rural and peri-urban communities were selected, six as controls and six as areas where the showmen were to deliver their health messages over a three month period. Two months later, a survey evaluation was done on key points of the health messages to test their impact on knowledge, attitudes and behaviour. Results indicated that the showmen were able to positively influence knowledge, attitudes and behaviour; that they were effective in both rural and urban areas; and that their effectiveness was not only limited to the uneducated.

Tumlison G. 1977.
An exercise in dental health education. Papua New Guinea Medical Journal, 20 (3): 125-130.

This is a description of an effective dental health education exercise, trying three different methods to improve the oral hygiene of school children in Papua New Guinea. It was clear from the results that the only method that brought any improvement was when the teachers and their families were involved, as well as the students. The teachers were motivated by a two day visit from the dental officer when he explained the causes of decay, examined families and gave individual instruction for cleaning teeth. The school children were then shown how to clean their teeth, and teachers supervised toothbrushing every day at the beginning of the health class. There was a dramatic rise in cleanliness and gingival health.

WHO, 1982.
The core elements: health education. In: Review of primary health care development. Unpublished document, SHS/82.3. Geneva.

In the chapter on the core elements of primary health care, there is a lengthy review of health education. The information is derived from questionnaires responded to by forty-two countries (60 percent of the countries studied). The material covers various aspects of health education, including the organization, generation of and support for, health education, manpower training, techniques, their role and use, priorities and targets, and finally inter-sectoral activity. From the presentation of material it is not easy to interpret changes in health education, although an impressionistic summary at the end suggests the major trends highlighting the countries' concerns. For example, many countries are re-examining the role and training of manpower in health education, and the emphasis is tending towards seeing health and development workers as potential health educators.

## C. COMMUNITY HEALTH EDUCATION PROGRAMMES

While there are many overlaps between the previous section and this one, it is worth distinguishing between community resources and programmes in the community. Many health educators focus on a particular disease or health problem, perhaps highlighted by the community, and attempt to inform and hopefully, to change, behaviour. Many of the annotations that follow describe such attempts in the field of malaria eradication, leprosy control, family planning motivation, guinea-worm control and breast-feeding promotion among others. They also often highlight the difficulties in getting communities to change, even when key people are involved in health education activities, and provide salient lessons that can be generalized to many other situations.

Many of the programmes are innovative and may inspire health educators willing to try experimental methods. They underline important points made in the introduction. First, in order to succeed, programmes must be planned locally and take into account local customs, habits and beliefs. Health educators need to question their own values in the local situation. Second, few health education programmes are evaluated well. Some high-cost programmes (using television for instance) have had rather doubtful results. Others need complex infra-structures for support (the cold chain, drug supplies) which are not sufficiently considered in the planning of the programme. More evaluation, both before implementation, and later, and preferably involving the community, could lead to a better and more effective use of resources.

Adamson P. 1982.
The Gardens New Internationalist 109 March:7-28.

An anecdotal, but vivid account of life in a slum area of Colombo, Sri Lanka. The article incorporates a critical assessment of the UNICEF-sponsored Environmental Health and Community Development project. The aims of the project were to install and upgrade latrines, and to install washrooms and clean-water stand pipes. Community health education was seen as a vital component of the project and 100 primary health care workers were trained as health wardens and the aid recipients encouraged to organize themselves into Community Development Councils with elected officials. The successes and failures of the project provide an excellent example of the overwhelming economic, political and social problems facing community health education in peri-urban slums, as well as raising interesting questions regarding the training, scope and future of primary health care workers as community health educators.

Ade Laoye J. 1980.
Selling health in the market place: the Araromi approach.
International Journal of Health Education. 23 (2): 87-93

A heartening report on the success of a village health education project in Nigeria which used a combination of health education techniques with local community involvement. One of the novel techniques used was to sell health in a local market town by setting up a health stall. Clean drinking water was provided for market-goers, demonstrations and information given on disease prevention. A pit latrine constructed from local materials was used as a prime exhibit, and free entertainment took the form of showing health education films. Villagers were trained to run the stall themselves, and this activity stimulated requests from others to have similar schemes in their villages.

Ademuwagen Z.A., Oduntan S.O., Familusi J.B. 1977.
Mother and Child Health in Africa: the Role of Health Education. Israel Journal of Medical Sciences 13(5): 508-513.

This article stresses that health education is, or should be, an integral part of mother and child health and other medical care programmes. The difference between health information (a tool) and health action (the desired result of health education) is stressed: the health-informed person is not necessarily a health-educated person until he adopts the anticipated health practice. It is a mistake to believe that the patient is the sole target of health education. Since husbands, relatives and traditional midwives all influence mothers in their socio-cultural environment, to say nothing of policy-makers planners and health personnel, they all should be involved in health education which should be directed to the community as a whole.

Agency for International Development (AID) 1982. Manual on Malaria Control in Primary Health Care in Africa, AID, Bureau for Africa. 111 pages plus appendices.

This manual contains a short section on Health Education and Community Participation raising valid general points on the need for a considerable degree of local involvement and understanding in any malaria control programme. Salient points are that primary schools, village councils, rural development activities, and religious organisations are community resources as valid as the clinic in health education programmes; that service provision must match the health message; and that the gathering of social science data and the identification of informal (e.g. traditional healers, leaders of womens groups) as well as formal leaders and local government employees is necessary. Appendix VI details an educational planning model for malaria eradication drawn up by Nyswander et al in 1959.

Akpovi S.U., Johnson D.C., and Brieger W.R., 1981. Guinea Worm Control: Testing the Efficacy of Health Education in Primary Care. International Journal of Health Education 24(4): 229-237.

This is an interesting evaluation of a project that aimed to limit the incidence of guinea worm in a district in Nigeria. Health education students and others from the African Regional Health Education Centre of Ibadan carried out a programme of training community chosen "health caretakers" to try to help villagers control the disease. The project was carried out sensitively, with full participation of the village communities, and in three years nine out of ten of the original experimental villages had adopted some form of control practice with positive health results. The authors are candid about the failures and difficulties, making this a valuable example for those who recognise the complex inter-action of social, political and economic forces that determine the success or failure of much health education.

Barnes S.T. and Jenkins C.D. 1972. Changing Personal and Social Behaviour: Experiences of Health Workers in a Tribal Society. Social Science and Medicine. Vol. 6: 1-15.

An excellent example of the sort of pitfalls malaria eradication programmes can meet, and of the usefulness of incorporating health educators and social scientists in the team to make the difficulties understandable and manageable. An anti-malaria programme in Surinam in the 1960s met considerable resistance from the Bush Negroes who inhabit the interior. WHO called in a health educator and a human behaviour consultant to act as a health promotion team. Using techniques of social anthropology and psychology these latter were able to ascertain previously unexplained reasons for resistance to the campaign and at the same time suggest modifications in the programme's techniques which minimized its disadvantages and inconveniences to the local populations and increased positive response to it.

Bertrand J.T., Zelaya J.D., Cisneros R.J., Morris L., 1981.
Evaluation of Family Planning Communications in El Salvador. International Journal of Health Education 24 (3): 183-194.

One of the primary means of promoting family planning has been information-education-communication programmes designed to inform the target population about the availability of family planning and to motivate them to adopt some form of contraception. The authors of this article attempted to evaluate for El Salvador a long-term "agressive" communication programme for family planning which reached its peak in the 1970s. Advantage was taken of a Contraceptive Prevalence Survey carried out in 1978. It was found that while mass media had reached 100% of women in the capital and 90% of rural women with at least one family planning message, the disparity between knowledge and use of of contraception remained. The main obstacles found here were: lack of husand-wife communication; rumours about the methods; belief that family planning is against God's will; lack of concern for the future of children. It is suggested that educational interventions tackling these barriers would be helped by improved interpersonal exchanges consistently backed-up by media programmes. This is an example of a health education programme where the values of the authors are probably totally incongruent with those of their target group.

Colle R.D. 1979.
Some Methods of Communicating with Rural Women. Educational Broadcasting International 12 (4): 153-157.

This paper considers the problem and potential of effectively reaching illiterate rural women with health messages. It examines the uses of audio-cassette tape recorders in Guatemala and Tanzania. In the Guatemala 'pila' project, the women's traditional laundry site was used for cassette programs which accompanied the women's work and gave out information on local health services and nutrition. Follow up interviews indicated that most women had heard the tapes at some point, and found them clear and helpful and "fun". In Tanzania audio cassette listening forums were set up in two villages as a follow-on from the mass radio learning campaigns on health and nutrition in the 70's. The tapes were produced by village women themselves working together with outside help, especially health workers, and aimed to improve nutrition and health and increase self-development skills among the women. The tapes, being locally produced, were seen as relevant by the women, and were used as a stimulus for discussion on relevant local health problems which followed each listening session.

Dharmalingam T. and Shanmugan P. 1981.
The Complexities of Health Education in Leprosy.
International Journal of Health Education. 24 (3): 176-182.

Various social and psychological factors which influence leprosy patients, their families and the community are considered. A health education component of leprosy control programmes is called for which will deal with these factors sensitively and in a manner that is well-informed not only medically but in terms of individual and local community response. An example is provided of a four week programme in a rural community of India, where leprosy was endemic and where a leprosy control programme had been under way for some time. The development of health education activities in five villages highlighted some of the social problems, indicated useful courses for a health education component and led to a marked increase in case detection.

Drummond T. 1975
Using the Method of Paulo Freire in Nutrition Education: an Experimental Plan for Community Action in Northeast Brazil. Cornell International Nutrition Monograph Series No. 3 Cornell University. 55 pages.

A nutritionist describes her attempt to translate the teachings of the Brazilian educationalist Paulo Freire into action, gaining the participation of the people of four rural Brazilian villages in a programme of nutrition education aimed at improving the nutritional status of young children. Interesting for those seeking applications of Freire's philosophy in the health field and/or those seeking innovative approaches in the field of nutrition education.

Feachem R.G. 1980.
Community participation in appropriate water supply and sanitation technologies: The mythology for the decade.
Proceedings of the Royal Society of London. 209; 15-29.

A brisk antidote to naive or over optimistic expectations from community participation in which the author explores some of the difficulties of appropriate technology. In looking at water supply systems, he suggests that the failure of a programme is not typically attributable to the wrong choice of pump, but to fundamental problems of poor management, inadequate institutions, scarcity of skilled manpower and so on. In relation to community participation he questions issues of practicability, relevance, cost, political context. Many of the recommendations on community participation require a cadre of staff that does not exist, working for bureaucracies that are already overstretched, paid by funds that are not available. Stimulating discussion.

Gramiccia G. 1981.
Health Education in Malaria Control - Why has it Failed?
World Health Forum 2 (3) : 385-393.

The article suggests four reasons for the failure of health education in malaria control: First, the type of population that suffers from endemic malaria is usually rural, isolated, apathetic, lacks capacity for understanding and has insufficient physical, mental and social resources. Second, the multiplicity of afflictions from which the people suffer takes away a good part of the motivation they might have for self-help in controlling malaria. Third, the disease is complex. Fourth, health education methods have not been well adapted to local situations. The author's main recommendations include: education programmes developed by epidemiologists, sociologists and health educators fully aquainted with the local situation and working together; the retraining or reorientation of health educators to provide an early and on-going education programme that incorporates a demonstration approach and is adapted to the problems of the specific population. See also: Brieger W.R. 1981. Health Education Can Help if Properly Conducted. A letter to Readers Forum, World Health Forum 2 (4): 578.

Brieger points out that Gramiccia's fourth reason, inappropriately conducted health education in malaria, is the most likely reason for programme failure. Techniques geared to providing knowledge and motivating "apathetic" populations miss the point that "behavioural characteristics that lead to the spread of malaria are rooted in economic and cultural factors, not intellectual ones". Motivation already exists, and it is up to the professionals to determine, and work within, the existing motivations, needs and interests of the community. It is important to read the two articles together.

Green L.W., Wang V.L., Deeds S., Fisher A., Windsor R., Bennett A., Rogers C., 1978.
Guidelines for Health Education in Maternal and Child Health. International Journal of Health Education.
21 (3) Supplement 33 pages.

Guidelines are presented for specifying objectives, identifying resources, selecting methods and evaluating the health education component for maternal and child health programmes. A model of health education is presented which emphasises: the careful delineation of the health problem; the specification of behaviours influencing the health problem; setting priorities among target behaviours on the basis of their relative epidemiological importance and their change-ability; and the identification of factors that predispose, enable and reinforce the behaviour. Useful theoretical outline.

Gueri M., Jutsum P., and White A., 1978.
Evaluation of a Breast-Feeding Campaign in Trinidad.
Bulletin of the Pan American Organisation. 12(2) : 112-115.

A campaign to promote breast-feeding was organized in 1974 by a Housewives Association in Trinidad. The campaign lasted six weeks, during which time five different posters were published and shown on TV and six different radio advertisements (15-20 seconds) were broadcast (on average four times per day). This article provides an assessment of the campaign, based on interviews with mothers delivering babies at the 2 largest public hospitals, (where half the Trinidad births take place) just after the end of the campaign. Analysis of results suggest that the campaign reached a large proportion of the target population. A close relationship was observed between the respondents exposure to mass media and their knowledge concerning breast-feeding and the value of human milk. There was also a positive correlation between avoidance of bottle feeding before infants were two months old and maternal familiarity with the campaign's media messages. Radio alone was more effective than press and TV combined.

Ho H.S. and Chee Eng Nam A. 1980.
Factors influencing the Outcome of Health Campaigns: A Case Study in Singapore. International Journal of Health Education. 23 (4) : 247-252.

A useful follow-up on a national health campaign against infectious diseases using a combination of exhibitions, film shows, schools competitions, newspapers radio and TV, in a country with four official languages and many spoken dialects. Of those aware of the campaign (52%), increased awareness of the facts of diseases were greatest among the younger, better educated and economically better-off, in other words, though the authors do not spell it out, the campaign failed to reach that part of the population to whom it may have been most useful. TV and radio were the respondents preferred media for future campaigns, though again the official language used in these probably meant it was poorly comprehended by dialect speakers. See also Ho S. 1979. Assessment of the Effectiveness of a Health Education Campaign in a Singapore Urban Community. In Abstracts: 10th International Conference on Health Education.

Isely R. 1982.
Evaluating the role of health education strategies in the prevention of diarrhoea and dehydration. Journal of Tropical Paediatrics 28: 253-61.

This is an excellent paper which focuses on one of the most important causes of death among children, diarrhoea and dehydration, and discusses the sort of health education interventions which may be helpful in primary prevention of diarrhoea, in the management of diarrhoea when it occurs and

in the management of dehydration. The author stresses the need to identify the social, economic and biological factors which affect the sort of behavioural interventions possible, and a useful end section discusses how to develop means of measuring change in behavioural factors. The strategies for health educators are suggested as: information, including mass media use, individual and group counsel, and community organization, and the evaluation questions are based on a health belief model which allows health educators to assess the likelihood of action in cases of childhood diarrhoea. The model could be applied to other health problems too, which makes this a particularly useful paper.

Jabre B. 1981.
Innovative approaches in nutrition education in the Pacific region. International Journal of Health Education 24 (2): 95-101.

The decline of local food production and a rise in the consumption of nutritionally inferior imported foodstuffs is leading to nutritional problems for the Pacific Islanders. A nutrition education programme stressing local resources is being undertaken by the South Pacific Commission using trainees sponsored by community-based organizations and utilizing existing groups such as women's village committees as well as health education in schools and radio programmes. Useful focus on an area which will be of increasing importance in many countries.

Lambert J. 1980.
Papua New Guinea's National Food and Nutrition Policy. Food and Nutrition. 6 (1): 28-33.

The section on nutrition education describes a national nutrition education campaign operating mainly through school teachers, agricultural extension officers and health workers. A variety of complex techniques have been used, from posters and slogans, through schools food gardens, radio talks and plays, and travelling theatre. Government restrictions on the sale and promotion of 'junk foods' are also being implemented. Useful background material.

Medis L.P. and Fernando P.A. 1977.
Health education in emergency situations: A cholera outbreak in Sri Lanka. International Journal of Health Education. 20(3): 200-204.

This describes a short-term health education programme to prevent the spread of cholera following a regional outbreak in 1974. The programme covered 65 villages with a population of 220,000. Initial problems were: both people and health workers doubted whether the notified cases were cholera.

There was a popular belief that diarrhoea was caused by the current food shortage and there was a general lack of faith in the efficacy of vaccination for cholera. Health education focused on three areas: information of the public by leaflets, posters, press releases, cinema, training sessions for health workers, teachers and volunteers; setting up a village committee to be responsible for planning and implementing the health education programme in each village. Short-term results included improved levels of knowledge regarding cholera; 50 percent vaccination against cholera, and in general, improved hygiene and clean-water practice.

Odumosu M.O. 1982.
The Response of Mothers to Health Education and the Incidence of Gastro-Enteritis Among their Babies in Ile-Ife, Nigeria. Social Science and Medicine 16 (14): 1353-1360.

This is a rare attempt to test the extent to which health education at infant welfare clinics is successful in changing behaviour. Since gastro-intestinal infections from various bacteria are the commonest causes of diarrhoea in the tropics among poorly nourished children during weaning, health education talks on good preparation and hygiene are given twice weekly at infant clinics. This study of 100 mothers showed that 82 percent were giving their babies (mean age 4.49 months) both breast and bottle, 5 percent were on bottle only, 11 percent were on breast only and 2 percent were on breast and 'forced feeding'. Although the different possible factors affecting a changed incidence of diarrhoea after health education are difficult to control, the authors conclude that health education did make a difference, and that there was a significant decline in the occurrence of episodes of diarrhoea after mothers had received health education. They point out, however, that not all mothers heed advice about washing hands or care in the preparation or protection of food.

Sanhu S.K., Gupta Y.P., Srivastava V.P., Gupta G.C., 1977.
Adoption of Modern Health and Family Planning Practices in a Rural Community of India. International Journal of Health Education. 20 (4):240-247.

A well designed study, carried out in five villages of rural India, which aimed at identifying the relationship between the adoption of health practices and several factors: socio-economic status; leadership behaviour; level of aspiration; exposure to media communication; and contact with health workers. Seven health practices were selected, five from the maternal and child health area and one each from the sanitation and family planning areas. When each variable was taken independently, contact with health workers was the only factor to show a significant correlation with health adoption. Mass

communication techniques had been made on a large scale for family planning messages only, where they had some impact. The authors propose that "a judicious sequencing of both methods of communication viz mass media and interpersonal contacts, could be tried to create a model for generating adoption."

Sevenhuysen G.P. 1978.
Informal Nutrition Education: Thoughts on its Use.
Food and Nutrition. 4 (1-2): 25-26.

A brief but useful discussion on the successes and failures of nutrition education. Three basic principles for effective nutrition education are suggested: the advice should be practical, short and relevant to local problems and felt needs, the message should be part of the advice given by many technical field workers such as agricultural agents, health and community development workers etc, and, if the advice involves the farmer or householder in added expense adequate funding should be available or the nutrition programme linked with an investment programme.

Sikes O.J. 1979.
Education in Family Planning: What Route to Take? What Difference Does it Make? International Journal of Health Education. 22 (4): 206-210.

A useful article on different approaches in family planning education with examples of increasing use of the mass media for providing the information necessary for informed decision-making. It concludes that neither a "grass-roots" nor "top-down" approach is the sine qua non of programme success but that what is needed is a combination of the most important elements in the two approaches.

Smith W.A. 1979.
A New Voice in the Village. Academy for Educational Development Washington 1979 (available Clearinghouse on Development Communication Washington).

This booklet published as an accompaniment to a video-tape, describes the design, application and evaluation of a nutrition education project in Tunisia, funded by AID and known as the "Dr. Hakim Mass Media Project". Essentially, it used radio to transmit short, advertisement-type health and nutrition messages targeted towards poor mothers. Results are somewhat inconclusive, although responses to certain questions on the evaluation questionnaire suggested that mothers attending clinics where staff had received special training, and where they received written material backing up the radio broadcasts, had been positively influenced by the programme.

Smith W. 1982.
Beyond Slogans: A Serious New Role for Radio. Development Communication Report. 37:2-3.

A short account of attempts made in two countries, Honduras and The Gambia, by their Ministries of Health, to test the effectiveness of social marketing applied to the prevention and treatment of acute infant diarrheoa. The campaign combines health worker training, specially designed printed materials, and widespread use of radio to reach isolated villages. In the Gambia mixing instructions for a simple sugar and salts oral rehydration therapy solution are being colour-coded on an inexpensive one-page flyer which is distributed free, and which also serves as a lottery ticket. The project will be evaluated. More information from Clearinghouse on Development Communication, 1414 22nd Street NW, Washington DC,20037 USA.

Tanil M.C., Azevdo A.C., 1978.
Community Participation in Health Activities in an Amazon Community of Brazil. Bulletin of the Pan American Organisation 12 (2): 95-103.

This describes an eight year health programme consisting of six doctors, a public health nurse, two social workers, and one educator. This team took charge of a 50 bed hospital and proceeded to co-ordinate its work with that of other health agencies in the area. The first community participation project was directed at reducing the town's infestation with vermin. Other projects followed: e.g. a nutrition education and recuperation centre for under-nourished children, which made extensive use of community participation and was supported and partially financed by the community. On the basis of this experience the authors set forth a number of general conclusions which may well have relevance for other projects which attempt to include the community. Useful.

Tiglao T V. 1982.
Health knowledge, attitudes and practices related to schistosomiasis. Hygie 1; 31-7.

Emanating from Leyte in the Philippines, this study looked at a schistosomiasis control programme to test people's knowledge on the causes, transmission and control of schistosomiasis and existing attitudes towards the current control programme, to identify messages that should be emphasised in an education programme. The results showed that, except for a hard core of 25 percent, people were aware of the problems, knew that the disease exists in the area, knew its symptoms and the parts of the body affected. They also knew what action to take when afflicted by the disease. However the author points out this does not guarantee changed behaviour.

Tonon A.M. 1980.
Concepts in Community Participation: A Case Study of Sanitary Change in a Guatemalan Village. International Journal of Health Education. 23 (4) Supplement 16 pages.

Community participation led to measurably improved sanitation behaviour in a rural Guatemalan Village according to this study. A health education team worked for 18 months with a rural community which had recently had piped water provided. Though the teams goals were to improve existing poor hygiene and health habits, they did this through a long-term community development approach in which villagers planned and participated in and organized change efforts, initially by establishing a Community Betterment Committee. An interesting example of how health and sanitation issues can be the spur for collaborative action among villagers little accustomed to community decision-making.

WHO, 1982.
Prevention of Coronary Heart Disease. Technical Report Series 678, 53 pages.

Coronary heart disease (CHD) has become the most important cardiovascular cause of premature disability and mortality in spite of the substantial knowledge concerning its prevention and control that has accumulated over the past three decades. Rates of CHD differ widely, rising in some countries, falling in others. Preventive strategies include: altering the characteristics of life-style and environment which are the underlying causes of mass disease (prevention in whole populations); in low-incidence countries preventing the development of these precursors of mass disease (primordial prevention in whole populations); within the population identifying and helping individuals at special risk; and preventing recurrences and progression of disease (secondary prevention) See p 39-41 on developing countries, with strategies and objectives. An excellent, practical guide.

## D. RESOURCE MATERIALS

There is a mass of resource material on health education. A few particularly relevant resources have been picked out; all are relatively easy to get hold of. They range from monthly publications of annotations to manuals on specific subjects like running radio listening campaigns. While not all are written specifically for the less-developed countries, they have features which make them useful for health educators everywhere.

ACTION/Peace Corps. 1978.
Community Health Education in Developing Countries: Getting Started. 215 pages. American Public Health Association, International health Programmes, 1015 Fifteenth Street, NW, Washington D.C. 20005, USA.

A how-to manual, simply and clearly laid-out, for the guidance of teachers, agricultural extension workers, social workers and other community-involved personnel who want to set up and carry through community health projects. It is divided into four parts: helping a community start a health project; planning, implementing and evaluating community health projects; some aids and methods in health education; and common community health problems. The emphasis throughout is on community involvement and communal problem-solving. The health education section considers individual and group educational methods; visual aids and mass media; and covers a variety of techniques from songs, dramas and puppet shows through to films and radio.

Bureau of Health Education. Current Awareness in Health Education. Bureau of Health Education, Centre for Disease Control, Public Health Service, U.S. Department of Health, Education and Welfare, USA.

This monthly publication of the Bureau contains abstracts of documents and descriptions of programmes arranged in chapters according to their major subject area. There is a section devoted to 'Community Health Education'.

Crowley D., Etherington A., Kidd R., 1981.
Mass Media Manual: How to run a Radio Learning Group Campaign. (Revised edition) Friedrich-Ebert-Stifting: Germany. 186 pages.

A clear, step-by-step manual, with a useful section on evaluation, based on successful compaigns run in Tanzania and Botswana. Useful short, selected bibliography.

De Lauture H. and Robineau L. 1979.
Material D'Education Pour La Sante En Afrique: Inventaire analytique de la production des pays francophones, Environnement et Developement du Tiers-Mode, BP 3370, Dakar, Senegal (ENDA).

Games, texts for radio programmes, films, posters, flannel-graphs, puppets, television programmes and other resources are listed in this useful catalogue which is directed particularly at Francophone countries in Africa. The name, address and cost of each resource is given.

Epskamp C. 1979.
Media, Education and Development: A Bibliography.
Bibliography No. 3. Centre for the Study of Education in Developing Countries, The Hague, The Netherlands. 94 pages.

Selected, annotated bibliography grouped into three sections: mass media; media development; and media, education and development. The author points out that in spite of the considerable literature on modern audio-visual media, evaluations of the educational impact of instructional media are rare.

Films for Family Planning Programs 1981.
Population Reports (J) 23 1981: J 493-522.

A useful review of the advantages and disadvantages of family planning films, with warning notes on their limitations especially for motivating people. It includes a classified catalogue of films and distributors.

Fuglesang Andreas 1973.
Applied Communication in Developing Countries: Ideas and Observations. The Dag Hammarskjold Foundation, Uppsala, Sweden. 124 pages.

A useful handbook of ideas and practices in communication in the developing world with some sound warnings on the pitfalls awaiting the 'expert'.

Fuglesang Andreas 1982.
About understanding: ideas and observations on cross-cultural communication. The Dag Hammarskjold Foundation, Uppsala, Sweden. 231 pages.

Designed for workers in adult education, primary health care and nutrition, this is essentially an updating and expansion of his earlier work by a recognised authority on information, cross-cultural communication and adult education in the Third World.

Gatherer A. Parfit J. Porter E., Vessey M. 1979.
Is Health Education Effective? The Health Education Council, London, UK. 92 pages.

An extremely useful compendium of health education studies over the last 10-15 years for which there has been some evaluation. Though reviewing mostly problems and approaches in the Western World, there is some data from developing countries, especially under the 'Community Methods' section. Well laid out, the publication has three main sections: theoretical discussion of the aims of health education and the purpose and direction of evaluation; abstracts of some 250 references, grouped according to the method of health education used, and a general summary of the overall findings with conclusions.

Health Education Index 1983.
B. Edsal and Co. Ltd., 124 Belgrave Road, London, SW1V 2BL, UK. 464 pages.

Principally for health education in schools and colleges in the UK, the index lists over 500 sources of supply and classifies over 9000 different items. Covers leaflets, film strips, slides, tapes cassettes, video cassettes, films etc. Hundreds of wall charts and posters are illustrated in miniature.

Hilton D. 1981.
Health Teaching for West Africa: Stories, Drama, Song. MAP International, P.O. Box 50, Wheaton IL60187 USA. 30 pages.

Developed by a medical missionary in Nigeria, from experience gained in a rural health training school (Lardin Gabas), this booklet offers a simple and practical guide to developing health teaching using strong local oral traditions of story-telling and parable, drama and song. Example stories, lessons and ideas are offered on the topics of: Malaria; Diarrhoea; Intestinal Parasites; Latrines; Malnutrition.
See also: Barrow R. Nita 1977. Rural Basic Health Services; The Lardin Gabas Way. Contact 41 October, Christian Medical Commission, World Council of Churches, Geneva, Switzerland. This also describes the Lardin Gabas Health Programme, with its community participation, village health committees, and use of traditional story-telling as a teaching method.

Interlit from the David C. Cook Foundation, 850 N. Grove Ave., Elgin, Mass. 60120, USA.

Quarterly journal, covering media communication skills, with the emphasis on print. An example of this publication is Using Pictures in Literary Work by Bruce Cook.

Miller D. 1977.
What's New? A Simulation of Social Change. Available: MAP International, P.O. Box 50, Wheaton, IL60187, USA.

A simulation game for 15-30 persons. Its objective is "to provide an activity by which participants may experience the processes and feelings generated within a community when a new value is introduced and its adoption encouraged."

Ministry of Health Zimbabwe/UNICEF 1981.
Baby Feeding: Behind and Towards a Health Model for Zimbabwe. Department of Nutrition, Ministry of Health Government of Zimbabwe, Harare, Zimbabwe. 62 pages.

An excellent and well illustrated little booklet which makes the case against the promotion and use of infant formula while promoting breast-feeding and the use of local food stuffs as supplements and weaning foods. A broad front of actions to protect and promote breast feeding is suggested, including: implementation of the WHO 'Code of Marketing of Breast-Milk Substitutes'; putting feeding bottles and teats on prescription; giving working women time off to breast-feed during the hours of work; avoiding the use of formula on maternity wards; educating health workers on the advantages of breast-feeding and the dangers of bottle feeding; and developing a campaign to protect and promote breast feeding. Though designed specifically for Zimbabwe, the clear and forthright style of the booklet and the thoroughness of the case it makes against commercial breast-milk substitutes suggests its modification and adaption to the particular circumstances of other African countries.

Newsletter of the Asian Community Health Action Network, Link. From ACHAN, Flat 2A, 144 Prince Edward Road, Kowloon, Hong Kong.

Publishes Link six times a year. Vol. II, 2, 1982 was devoted to Community Health Education in Medical Schools in Korea, Vol III, 1, 1983 contains some useful discussions on self-sufficiency in community health programmes.

Non-Formal Education and Health: A Selected, Annotated Bibliography. 1981.
Non-Formal Education Information Center, College of Education, Michigan State University, East Lansing, Michigan 48824, USA. 56 pages.

A useful annotated bibliography of some of the recent (post-1975) literature in the area, this contains full addresses for obtaining some of the more " fugitive" materials. The seven page section on health education is one of nine sections, and is itself sub-divided into three subsections: general; manuals, practical materials, guides; and radio, TV and audio-cassettes. See also their annotated bibliography Children: Health, Education and Change. 1981. 40 pages. There is a section on primary health care.

Parlato R., Parlato M.B.O., Cain B.J. 1980.
Fotonovelas and comic books. Communications and Educational Technology Division, Office of Education and Human Resources, A.I.D., Washington D.C. 243 pages.

A detailed review of the potential of popular graphic media in presenting development themes, with emphasis on their use in communicating information to illiterates and semi-literates, especially in the area of family planning.

Rau W.E. 1978.
Impromptu drama for development: an experience from Zambia. Ideas and Action 125: 17-19. Freedom from Hunger Campaign/ Action for Development, F.A.O. 00100 Rome, Italy.

The use of drama in health education, together with a synopsis of a play on immunisation, which could be reproduced in a number of settings.

Saunders D.J. 1974 (revised 1979).
Visual Communication Handbook: teaching and learning using simple visual materials. United Society for Christian Literature, Lutterworth Educational, Guildford and London, UK.

Simple and clear basic manual on the communication of ideas through a wide variety of methods from pictures and posters, through puppet shows and drama to a how-to-do-it of projection screens. Much of the book is based on ten years experience in rural India.

Schweser H.O.
Manual for community health education for the Caribbean People-to-People Health Foundation Inc., Project HOPE, Washington D.C., USA. 261 pages.

A manual covering the contributions that health workers and others can make in the field of community health education in the Caribbean. As well as providing background information on community attitudes it details the role of health workers, those in allied disciplines, and voluntary organizations in situations where health education is appropriate.

Scotney N. 1976.
Health Education. Rural Health Series 3, Amref, Nairobi, Kenya. 141 pages.

A useful short book - largely written for health workers in health centres, with one chapter on community health education.

The Sun, Water and Bread. 1978.
Report on an Appropriate Technology Workshop in Food and Nutrition for Family Welfare Educators and Home Economists. Botswana. 38 pages.

An account of a workshop in which participants were involved in trying out the many ideas generated in the villages and with the villagers. Useful sections on communication problems and the use of popular theatre and song followed by discussion.

Report on 10th International Conference on Health Education.
London 2-7 September 1979.
Published by the Health Education Council, England, and The Scottish Health Education Group. 1980. 167 pages plus appendices.

The Conference was entitled 'Health Education in action - achievements and priorities' and was attended by delegates from 76 countries. The Conference was organized around three main themes: public policy; youth; methodology. The report contains the main addresses to Conference and the 'keynote' papers on each main theme and sub-theme plus an evaluation of the Conference and a list of the names and addresses of all Conference delegates. See also: 10th International Conference on Health Education London September 1979. ABSTRACTS. 61 pages. Issued as a separate publication from the Conference Report, it contains an abstract of all the papers presented at the Conference plus alphabetical lists of authors, countries and subjects. See also: Special issue on the 10th International Conference on Health Education. International Journal of Health Education. 22(3) 62 pages. A summary of some of the main themes, papers and conclusions of the Conference. See especially the papers by Krishnamurthi C.R. and Green L.W. and the Supplement on community organization for health education by Isely, Sanwogou and Martin.

UNESCO.
Reports and Papers on Mass Communication Paris, France.

An ongoing series of useful papers and reports dealing with individual projects or general issues in mass communication for the dissemination of information and education.

UNICEF.
Assignment Children.

A journal concerned with children, women and youth in development. Issues especially pertinent for community health education re: Education and community self-reliance : innovative formal and non-formal approaches. 1980 51/52 and Community participation : current issues and lessons learned, 1982 59/60.

Voluntary Health Association of India. 1977.
Better Health Care. A booklet produced in English and several Indian languages. Available from Safdarjung Development Area, New Delhi, 110016, India.

A small basic booklet on guidelines to child care, with ample photographs, designed as an aid-memoire and teaching aid for community health workers, but also for personal use by village families with a literate member.

Werner D. and Bower B. 1982.
Helping Health Workers Learn. The Hesperian Foundation, Palo Alto, USA. 590 pages.

An excellent, clearly written and illustrated book full of ideas, methods and aids for instructors at the village level. Especially designed for use with Werner's 'Where There is No Doctor', a village health care handbook. Most chapters have something of relevance for community health education, but see especially the chapters on 'Looking at Learning and Teaching' and 'Learning and Working in the Community'.

W.H.O. 1981.
Health Education Methods and Material in Primary Health Care. Appropriate Technology for Health Newsletter. 10 24 pages. Available from the Division of Strengthening of Health Services, WHO, Geneva.

A series of brief articles illustrating a wide variety of health education techniques and materials currently being used in health education programmes throughout the developing world.

## E. RESOURCE CENTRES

Resource Centres carry material which may be useful in health education; they sometimes offer courses, produce information, visual aids, and other such background material. What follows is a list of some of the better known centres: all countries will have a number of organizations which may have useful resources, and health educators should explore as widely as possible in their own countries as well as tapping the centres mentioned in this bibliography. Universities, adult education institutes, broadcasting agencies, consumer groups, may all have resources which can be put to good effect.

African Regional Health Education Centre, Department of Preventive and Social Medicine, University of Ibadan, Nigeria.

Set up in 1975 and supported by UNICEF, the Ford Foundation and WHO, the Centre trains health educators from within Nigeria and from other African countries. They offer an MPH (Health Education), a two-year postgraduate course, and an Advanced Diploma in Health Education as a one-year non-graduate programme.

African Medical and Research Foundation, AMREF, Wilson Airport, PO Box 30125, Nairobi, Kenya. London Office: London House, 68 Upper Richmond Road, SW15.

Produces books, manuals, journals and newsletters for front-line health workers in Kenya and East Africa generally, see especially: Defender: a three monthly journal answering readers letters and giving health advice and information, and AFYA: a journal for medical and health workers. Some AMREF publications are available through TALC.

Appropriate Health Resources and Technologies Action Group Ltd, (AHRTAG) 85 Marylebone High Street, London, W1M 3DE, UK.

Concerned with the development of equipment and techniques for health care at community level. Community health education is one of its special interests along with dental health, diarrhoeal diseases, disability prevention and rehabilitation etc. Information services; publications.

The British Life Assurance Trust for Health Education, (BLAT), Blat Centre for Health and Medical Education, B.M.A. House, Tavistock Square, London, WC1, UK.

Library, materials and information service on the training of health workers. They produce a useful guide six times a year which contains sections on new teaching and learning materials, research abstracts, and general information.

Caribbean Food and Nutrition Institute
P.O. Box 140, Kingston 7, Jamaica

Produces Cajamus, a quarterly publication, free for developing countries.

Child-to-Child Programme, Institute of Child Health, University of London, 30 Guilford Street, London, WC1N 1EH, UK.

A wealth of data, in several languages, for teaching older children who care for young children how to do more. Applicable to normal and handicapped children. Newsletter and information sheets.

Clearinghouse on Development Communication, 1414 Twenty-second Street, NW, Washington D.C. 20037, USA.

Information services; publications, including quarterly newsletter; training workshops and seminars in communication. 'Project profiles' on various AID projects. Produces Development Communication Report, a quarterly journal, free to readers in developing countries, which often has very useful information and practical ideas.

Consumer Association of Penang (CAP), 27 Kelawi Road, Penang, Malaysia.

An independent and non-profit organization, CAP was set up in 1970. Its concerns are not only with consumer products but to inform, educate and represent the people on such issues as basic needs, consumer protection and environmental destruction. It takes a critical stand on development issues and has a rural education programme.

Educational Resources Information Centre (ERIC), P O Box 190, Arlington, Virginia 22210, USA.

ERIC has a large collection of material on communications technology, distance education, non-formal community education activities, some of which may be relevant for human activities too.

Health Education Materials Information Service, (HEMIS) Centre for Medical Education, University of Dundee, Dundee DD1 4HN, UK.

An information retrieval service which will provide a comprehensive guide to audio-visual material available on any specific health education topic. The service is intended to be of value to all concerned with the promotion of health. In requesting malerial please be as specific as possible about topic, audience level and which audio-visual media are acceptable. There is a service charge.

The Health Education Council, 78 New Oxford Street, London, WC1A 1AH, UK.

The Council has a resources and information library with a complete section devoted to audio-visual aids and materials - lists of films, tapes etc. available. There is also a bookshop with books, leaflets and posters on all aspects of health education relevant to developed Western world (Britain) with some pamphlets and posters in the languages of ethnic minority groups in Britain eg Bengali, Gujarati, Hindi, Punjabi, Urdu, Spanish, Italian, Greek, etc.

International Council for Adult Education, 29 Prince Arthur, Toronto, Canada M5R 1BZ.

International Council that produces work of relevance to health education. One example is the Participatory Research Project, an annotated bibliography, December 1977.

International Development Research Centre, IDRC Box 8500, Ottawa, Canada, K1G 3H9.

The Centre publishes, among other materials: Low-Cost Rural Health Care & Health Manpower Training an annotated bibliography with special emphasis on developing countries.

International Extension College, 18 Brooklands Avenue, Cambridge, CB2 2HN, UK.

Information, materials and expertise on all aspects of distance learning. They produce About Distance Education a ten-page newsletter, three times a year, and a series of broadsheets on the same subject.

International Planned Parenthood Federation, (IPPF), 18-20 Lower Regent Street, London, SW1Y 4PW, UK.

The Federation publish: IPPF Co-operative Information Service - a booklet with a constantly up-dated list of references and addresses in the whole area of family planning and population.

International Union for Health Education, (IUHE), 9 Rue Newton 75116, Paris, France.

Parent organization for the international conferences on health education. Produces Hygie, a quarterly journal on health education, which has replaced the International Journal of Health Education.

Non-Formal Education Information Centre, College of Education, 237 Erickson Hall, East Lansing, Michigan 48824, USA.

They produce The NFE Exchange, and occasional papers in various fields, including health. See, in particular Non-Formal Education and Health : A Selected Annotated Bibliography 1981.

Teaching Aids at Low Cost (TALC), Institute of Child Health, 30 Guilford Street, London, WC1 1EH, UK.

TALC provides low cost sets of slides, flannelgraphs, material charts and books to help in teaching. See especially their slide sets on "Communication in Health" ways in which a health worker may improve communication; and "Diarrhoea Management", designed to help primary health care workers bring knowledge of the management of diarrhoea by oral rehydration to their local communities.

United Nations Information Centre, 14-15 Stratford Place, London, W1N 9AF, UK.

Library and Reading Room.

Voluntary Health Association of India, C-14 Community Centre, Safdarjung Development Area, New Delhi, 110016, India.

They produce material and information on health projects they support all over India.

## F. 1985 UPDATE

A few new references have been added in this reprinted version of Community Health Education, either because they came out after the first issue was printed, or because they are part of a new trend. During 1984, largely due to the efforts of UNICEF, much more emphasis was put on communication as an essential part of health education. Social marketing is one of the approaches being advocated in this attempt to incorporate some of the dynamism of communications theory into health education programmes.

Abed F.H. 1983.
Household teaching of ORT in rural Bangladesh.
Assignment Children 61/62 : 250-265.

BRAC, a non-government agency in Bangladesh, launched an ambitious programme in 1980 to teach oral rehydration therapy to 2.5 million households in five of the country's twenty districts. Essentially a teaching programme, mothers are taught face-to-face in their own homes seven points to remember about how to treat diarrhoea and how to make oral rehydration solution. Teams of oral rehydration workers, team coordinators and a cook cover approximately 3000 households (a union) in a month (10 households a day) and then move on to the next union. Results so far are very positive, with almost 90 percent of mothers able to make up the solution even six months after being taught.

Assignment Children. 1983 and 1984.
Issue numbers 61/62 and 65/68. UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Entitled the Child survival and development revolution the first issue is devoted to the four interventions that UNICEF is promoting to combat child mortality in the developing world. There is an introduction to growth charts, oral rehydration therapy, breast-feeding and immunization (GOBI) and a good chapter by Rohde on the rationale behind the thinking and strategies to save children's lives. Other sections look at a variety of aspects of the GOBI interventions. In the second 1984 issue, called Going to scale, are outlined the strategies for converting small-scale into nation-wide programmes in order to accelerate and expand the child survival and development revolution. Innovative communications methodologies are seen as the way forward, and sections by Grant and Vittachi explain the importance of social marketing and taking a demand approach in order to change people's perceptions. There are eight case studies illustrating these points. Essential reading for health educators. See also Grant J. The State of the World's Children, Oxford University Press, Oxford, 1985.

Brieger W., Adeniyi J., Oladepo O., Ramakrishna J., Johnson D. 1984.
Impact of community need differentials on health education planning. Hygie III : 42-48.

The essential message of this case-study is that communities do not necessarily perceive health problems as priorities, and that health educators have to understand this and work within the limits posed. The authors suggest four different approaches to be used in planning to meet different community perceptions

and demands in different situations. They then give illustrations from their own practical experience in three communities in Nigeria.

Convergence, 15:2, 1982 and Our Own Health, 1984. Special report: adult education and primary health care and Report of the role of adult education in community involvement in primary health care. Published by the International Council for Adult Education, 29 Prince Arthur Avenue, Toronto, Canada M5R 1BR.

This issue of Convergence marked the initiation of an attempt by the International Council for Adult Education to stimulate a dialogue on the links between adult education, primary health care and health education. It is a collection of theoretical papers by people working in the fields of health and of adult education, and of specific illustrations of adult education in action in health settings. Our Own Health was part of the same process of linking adult education and primary health care. It documents, through the use of case studies in Canada, Chile, India, Indonesia, Nicaragua, the Philippines, Senegal, Tanzania and Venezuela, effective uses of adult education promoting and strengthening community involvement in health care. These are valuable readings because it is rare to find an inter-sectoral approach to health education.

Education for health, 1984.
Newsletter issued by the World Health Organization in collaboration with the John J. Sparkman Centre for International Public Health Education (SCIPHE).

Initiated in 1984, the aim of this newsletter (which looks like a small journal) is to encourage a dialogue between readers on innovative ways to promote individual, family and community self-reliance in health. It carries short, easy-to-read descriptions covering conceptual issues, community involvement, training for new roles and research as well as a section on news from around the world. It is issued in English, French, and Spanish, and contributions or queries should be addressed to: Health Education Service, Division of Public Information and Education for Health, WHO, 1211 Geneva 27, Switzerland.

Favin M. 1985 (forthcoming, July).
Health Education. Information for Action Series, World Federation of Public Health Associations, 1015 Fifteenth Street, N.W., Washington, D.C. 20005, USA.

One of the series co-funded by UNICEF and the Aga Khan Foundation, this is a useful overview of the issues in health education. Addressed specifically to planners, programmers and administrators of primary health care and related programmes in developing countries, the book contains a number of interesting case studies, as well as a bibliography.

Feachem R. 1984
Interventions for the control of diarrhoeal diseases among young children: promotion of personal and domestic hygiene. Bulletin of the World Health Organization, 62 : 467-476.

This study provides some evidence to suggest that hygiene education can improve hygiene and reduce diarrhoea morbidity by between 14 and 48 percent. Education interventions are attractive because they are relatively inexpensive and they may achieve lasting changes in behaviour. The author concludes that while such programmes should continue, attention should also be paid to research, in order to improve the cost-effectiveness of hygiene education. See also Isley R.B. 1982. Evaluating the role of health education strategies in the prevention of diarrhoea and dehydration.

Hubley J. 1984.
Principles of health education. British Medical Journal 289 : 1954-56.

This article addresses some of the basic questions about health education. What to change? Where should health education take place? Who should do health education? How should health education be carried out? Many reasonable suggestions are made under these headings. The tendency, however, is to ignore the process of community involvement, and the need for dialogue in health education: to see health education as a way of promoting community support for primary health care and government control measures rather than as a method for stimulating a dialogue with communities over their health problems and priorities for action.

Isely R.B. 1982.
Planning for community participation in water supply and sanitation: accounting for variability in community characteristics. Hygie 1 : 39-41.

Noting that variability among rural communities is enormous, Isely argues that community response to water and sanitation projects will be very different, depending on many factors that affect variability. He suggest a model for assessing the varying degrees of readiness for community participation by first categorising communities at four levels, and then proposing a check list of physical, biological, economic, demographic, socio-cultural and local organizational characteristics which may be included in an initial community assessment. A useful short paper.

Israel R.C. 1984.
Recent developments in social marketing and their implications for international public health education. Hygie 111 : 50-53.

A useful brief overview of the latest approach to marketing communications techniques. Israel gives a brief introduction to the concept of social marketing, calling on health educators with their serious commitment to improving people's health, to take on the effective techniques used in social marketing. He looks briefly at some of the more significant projects using this approach, both in the USA and in the developing world, and ends up with a plea for more appropriate teaching curricula, which include social marketing as part of courses in health education.

Israel R. and Tighe J.P.N. 1984.

Nutrition Education: the state of the art review and analysis of the literature. Nutrition Education Series, issue 7. UNESCO, Paris.

The short analytical introduction to this annotated bibliography gives a coherent overview of the latest trends in nutrition education. The authors suggest that there is a growing interest in applying skills from the social sciences, epidemiology and communications to the solution of nutritional problems. More than three hundred and eighty annotations follow in six different sections: policy issues; conceptual approaches; baseline information and ethnographies; case studies from all over the world; exemplary materials and finally, evaluation. Very useful to those new to nutrition.

Laver S. and Saunders C.R. 1984
Curriculum development for health education - preliminary report and a holistic approach. Central African Journal of Medicine 30 : 202-4.

During a farm health worker training project in Zimbabwe it became evident that teaching materials were not appropriate. Although basic information on specific health topics was accurate, it was also obviously insensitive to the cultural problems and beliefs of the community. It was decided to redesign the health curriculum, working with the community health workers themselves (and including others such as a research assistant, and social worker). The team identified five priority problems (malnutrition, sexually transmitted diseases, poor personal and community hygiene, malaria and changing cultural values). The process of re-designing the curriculum was itself very important, and led to the adoption of drama as a method of communicating messages. Community halls, beerhalls and football fields have been used as venues for health education drama. A heartening example of how health education can be made more appropriate, and how the process of involving health workers can lead to improved communications.

Morley D., Rohde J.E. and Williams G. 1983.
Practising health for all. Oxford University Press, Oxford. 333 pages.

There are several chapters in this book that are particularly relevant for health education. Hilton's 'Tell us a story: health teaching in Nigeria', describes how stories, drama and songs have become an essential feature of PHC in one community-based PHC programme. Hilsum shows how a nutrition project in the Dominican Republic developed into a strong women's movement aiming at fundamental social and economic changes in their society. Edwards and Lyon suggest that the technique of community assessment is a most effective way of stimulating and maintaining community participation in planning, implementing and evaluating health services. They give some examples from their own experience in Sierra Leone. These are the chapters that focus most closely on aspects of health education, but many of the others are also relevant, and make interesting reading.

Population Reports. 1980 Social Marketing: does it work? Series J, 21. Population Information Program, Johns Hopkins University, Hampton House, 624 North Broadway, Baltimore, Maryland 21205, USA.

This whole issue is devoted to discussing social marketing in family planning. Social marketing promotes, distributes and sells a contraceptive product to consumers, uses existing sales outlets, at low, subsidised prices, and with the overall social goal to expand contraceptive use. Experience from 30 social marketing projects suggests that this combination works. Whether it is a success in other projects is not so clear, nor is it discussed here. However many important issues related to social marketing are raised, and there is a useful bibliography at the end.

WHO. 1984.
A manual on health education in primary health care. (Draft). (Prepared by WHO and the African Regional Health Education Centre, Ibadan, Nigeria).

The major objective of this manual is to enable people to define their own problems and needs, to understand what they can do about those problems, and then to decide on the action most appropriate to promote healthy living and community well-being. It is addressed to health and community workers, and aims to integrate effective learning methods and approaches into the planning, delivery and evaluation of PHC services; to assist in the design implementation and evaluation activities together with communities; and finally, to transfer educational and programme planning skills to communities and health workers. It is attractively produced in seven different sections, very clearly written and has a strong practical base with many suggestions and examples. It should be of great use in many situations, and health educators should request that the present 'provisional' draft is transformed into a permanent, widely disseminated manual.

## Author Index

## Author Index (Cont)

## Author Index (Cont)

## Country Index

**The Evaluation and Planning Centre (EPC) is a multi-disciplinary group concerned with health policy, planning, management and evaluation issues in developing countries. Through research, overseas assignments and teaching it focuses on:**

- national health policies and planning
- district health services
- primary health care
- health services management
- refugee health care

The Centre has close working links with similar groups in developing countries.

EPC is an independent research unit within the Division of Community Health at the London School of Hygiene and Tropical Medicine.

The staff hold academic teaching and research posts recognised by the University of London.

**EPC receives support from:**

- London School of Hygiene and Tropical Medicine
- Overseas Development Administration
- World Health Organization and UN agencies
- Aid agencies, foundations and research councils

**EPC staff specialize in:**

- epidemiology and community health
- development and health economics
- medical and social anthropology
- health policy and sociology